84 - 1353 (1)

No.

Office - Supreme Court, U.S.
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In the Supreme Court of the United States

OCTOBER TERM, 1984

JAMES P. KARTELL, HERBERT W. HORNE, JR.
AND HARRY D. WILSON, JR.,
PETITIONERS,

v.

BLUE SHIELD OF MASSACHUSETTS, INC.,
RESPONDENT.

Petition for Writ of Certiorari to the United States Court of Appeals for the First Circuit

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February 1985

ADDISON C. GETCHELL & SON, INC. - THE LAWYERS' PRINTER - BOSTON

Question Presented.

Whether the Court of Appeals correctly held that provider contracts by which a market-dominant health insurer imposes a maximum fee schedule upon physicians are categorically lawful under Sherman Act § 1, without evaluation under the rule of reason and notwithstanding the District Court's undisturbed findings, after trial, that the contracts unreasonably restrain competition in the relevant geographic market for physicians' services.

Parties to the Proceeding.

The petitioners named in the caption (Drs. Kartell, Horne and Wilson) are three of the four original plaintiffs; the fourth withdrew during the trial court proceedings. Dr. Grant V. Rodkey, Dr. Henry Brown and the Massachusetts Medical Society intervened as additional plaintiffs represented by separate counsel.* In addition to the respondent named in the caption (Blue Shield of Massachusetts, Inc.), Blue Cross of Massachusetts, Inc. was a defendant and the Massachusetts Commissioner of Insurance intervened as a defendant; both were dismissed from the action by the District Court (see A. 72) but the Massachusetts Commissioner of Insurance was nonetheless permitted to participate in the Court of Appeals as an appellant.

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* These "intervenor-plaintiffs" are filing a separate petition for a writ of certiorari.

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Petition for Writ of Certiorari to the United States Court of Appeals for the First Circuit

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James P. Kartell, Herbert W. Horne, Jr., and Harry D. Wilson, Jr. (plaintiffs below) petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the First Circuit entered on November 28, 1984, reversing the injunction in their favor entered by the United States District Court for the District of Massachusetts following a non-jury trial.

Opinions Below.

The opinion of the Court of Appeals (A. 1-A. 27) is reported at 749 F.2d 922. The opinion of the District Court (A. 28-A.

68), which includes its findings of fact and conclusions of law, is reported at 582 F. Supp. 734.

Jurisdiction.

The judgment of the Court of Appeals (A. 69-A. 70) was entered on November 28, 1984. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254 (1).

Statute Involved.

Section 1 of the Sherman Act, 15 U.S.C. § 1, provides in pertinent part:

> Every contract, combination in the form of trust or otherwise, or conspiracy in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal.

Statement of the Case.

Petitioners are physicians engaged in private practice in the Commonwealth of Massachusetts. Respondent Blue Shield is the dominant private insurer of physicians' services in Massachusetts; its subscribers amount to approximately 56 percent of the total population and 74 percent of the privately insured population (A. 40).[1] With limited exceptions, Blue Shield covers only services by physicians who have entered into its standard-form Participating Physician's Agreement, which includes the maximum fee terms challenged in this action (A. 34).[2] The result is that — as the District Court con-

[1] As noted *infra*, the Court of Appeals did not set aside any of the District Court's findings. Accordingly, the factual statements herein are supported by references to the District Court's findings. All references to "Blue Shield" are to respondent Blue Shield of Massachusetts, which serves the entire state.

[2] The District Court determined at an earlier stage of the case that this refusal to deal with "nonparticipating physicians" was mandated by Massachusetts law and therefore not subject to anti-

cluded in findings undisturbed by the Court of Appeals — "Massachusetts physicians have absolutely no meaningful economic choice except to agree to the pricing terms unilaterally established by [Blue Shield]" (A. 54). Over 99 percent of them have in fact so contracted (*id.*).

The Participating Physician's Agreement provides, with limited exceptions, that Blue Shield's insurance payment shall be the physician's sole compensation for a covered service, precluding any additional payment from his patient (A. 35). In other words, "balance billing" of patients is contractually prohibited. Moreover, as the Court of Appeals acknowledged, the method by which Blue Shield determines the amount of its insurance payment "has evolved, through the use of various 'capping' devices, towards payment of a 'fixed fee,' determined by Blue Shield, for each particular type of service" (A. 4; see A. 36-A.39, A. 59-A.60). Thus, the effect of the contractual ban on balance billing is that Blue Shield not only fixes the amount of its insurance liability for each category of medical service but also largely controls the fees that physicians may charge, without regard to individual skill or experience, to the detailed nature of the treatment actually given, or to any other circumstances unique to a particular transaction between physician and patient.[3]

This action was begun in March 1978 to seek an injunction under Section 16 of the Clayton Act, 15 U.S.C. § 26, on the ground that this contractual regulation of fees by insurers violates the Sherman Act.[4] In earlier decisions not material

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trust attack. See *Kartell v. Blue Shield of Massachusetts, Inc.*, 542 F. Supp. 782, 788-791 (D. Mass. 1982). This determination is not challenged here by these petitioners.

[3] In 1982, Blue Shield's "fee schedule system" capped physician compensation for about 46 percent of all covered services (A. 59).

[4] There are no claims for damages in this action. The intervenor-plaintiffs subsequently filed an action seeking treble damages. *Rodkey, et al. v. Blue Shield of Massachusetts, et al.*, D. Mass. No. 82-317-C. That action remains pending in its incipiency.

to the present petition, it was determined that the ban on balance billing is not immune from antitrust scrutiny by reason of the state action doctrine or the McCarran-Ferguson Act's exemption of the "business of insurance," and that it does not violate Section 1 *per se*.[5] These decisions are not material here because petitioners do not pursue any *per se* claim in this Court and because the Court of Appeals did not consider any immunity issues, but decided instead to "proceed directly to the antitrust merits, which, on our view of the case, are dispositive" (A. 5).

These "antitrust merits" were the subject of full discovery and a lengthy non-jury trial on the "one central issue ***: whether, as judged under the rule of reason, Blue Shield's ban on balance billing by participating physicians imposes an unreasonable restraint on competition" (A. 31). Following the trial, the District Court made detailed findings leading to the conclusion that the provision of the Participating Physician's Agreement banning balance billing does in fact unreasonably restrain competition in the market for physicians' services in Massachusetts (A. 67). It therefore entered an injunction against enforcement of that ban (A. 72-A. 73). The Court of Appeals did not set aside any of these findings as clearly erroneous under Fed. R. Civ. P. 52(a), but held that this contractual restraint is permissible as a matter of law notwithstanding its anticompetitive effects; it therefore ordered judgment for Blue Shield.

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[5] *Kartell v. Blue Shield of Massachusetts, Inc.*, 592 F. 2d 1191 (1st Cir. 1979) (reversing dismissal on state action grounds); 384 Mass. 409, 425 N.E.2d 313 (1981) (answering state-law questions concerning state action certified by the District Court), 542 F. Supp. 782 (D. Mass. 1982) (deciding immunity questions and denying plaintiffs' motion for summary judgment on a *per se* price fixing theory). In addition, the Court of Appeals dismissed an appeal by the intervenor-plaintiffs from an order declining to expand the scope of the issues and the relief sought. *Kartell v. Blue Shield of Massachusetts, Inc.*, 687 F.2d 543 (1st Cir. 1982). The prior history of the case is summarized at A. 28-A. 32.

The District Court's Findings.

As previously noted, the District Court found that Massachusetts physicians are economically coerced to agree to Blue Shield's regulation of their fees under the Participating Physician's Agreement. It then went on to examine this contractual restraint under the classic criterion of the rule of reason — *i.e.*, "whether the ban on balance billing has the net effect of *promoting* or *suppressing competition* in the market for physicians' services in Massachusetts" (A. 50).[6] The Court found an absence of procompetitive effects because a mere reduction of prices to a more "reasonable" level than would otherwise prevail is not procompetitive (A. 50-A. 52). By the same token, the Court held that the ban would not violate the rule of reason unless it results in some "'effect on price formation, or other restraint of trade, independent of what the contract terms • • • require'" (A. 56), *i.e.*, "anticompetitive effects that reach beyond the price terms of the provider agreements" (A. 53).

While recognizing the differences between the rule of reason issue before it and the horizontal price fixing issue before this Court in *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982), the District Court looked to *Maricopa's* statement of the competitive dangers of maximum price restraints upon physicians as the touchstone for its rule of reason inquiry:

> "In this case the rule is violated by a price restraint that tends to provide the same economic rewards to all practi-

[6] The Court had previously found that this is the market in terms of which the ban on balance billing should be evaluated, rejecting plaintiffs' further contention that they had standing to complain of adverse effects on competition in the Massachusetts health insurance market (A. 41-A. 46). The Court also rejected Blue Shield's argument that the physicians' services market has special characteristics making application of normal antitrust rules inappropriate (A. 48-A. 50).

> tioners regardless of their skill, their experience, their training, or their willingness to employ innovative and difficult procedures in individual cases. Such a restraint also may discourage entry into the market and may deter experimentation and new developments by individual entrepreneurs.* * * "

(A. 59, quoting from 457 U.S. at 348). The District Court went on to find that "many of these anticompetitive effects have materialized in the present case" (*id.*).

The District Court's analysis of the evidence, including both expert testimony and testimony by several physicians as to specific effects of Blue Shield's fee regulation, led it to find that

> "As the Supreme Court predicted in *Maricopa*, those doctors in Massachusetts wanting to compete by offering innovative or 'premium' services — services requiring more of the doctors' time and expenses — are discouraged from doing so because defendants' pricing structure presumes that doctors' services are fungible. Defendant Blue Shield pays all doctors at the same 'customary' maximum price level regardless of their levels of skill, their experience, their willingness to employ new procedures, or the levels of care they provide. Thus, the Blue Shield maximum fee system permits no financial reward for excellence, nor does it provide an incentive for individual qualitative improvement or innovation."

(A. 60). Instead, its effect is to place a premium on "volume — the number of procedures performed" (*id.*). And "Blue Shield's reluctance to provide full remuneration for innovative procedures, coupled with its ban on balance billing, discourages physicians from undertaking the training and purchasing the equipment necessary to learn and offer [an] * * * innovative * * * procedure" (A. 62). The District Court's focus was not on the reasonableness of the amounts that Blue Shield pays, but rather on the fact that the ban on

balance billing precludes differentiation among physicians and thereby eliminates incentives for innovation that would otherwise exist; the Court observed that "it is especially important that during the early, formative development of a medical technique, the market, not Blue Shield, should determine the relative value of the procedure" (A. 62 n. 25).

Accordingly, the District Court concluded that "the restraint has a deleterious effect on competition in [the market for physicians' services in Massachusetts] far exceeding the mere diminution in doctors' earnings that results directly from the terms of the Participating Physician's Agreement" and that "this effect is not offset by any demonstrable procompetitive effect" (A. 67). It found that this impairment of competition "reduces the quality of medical care in Massachusetts because it suppresses the normal market-generated incentives for physicians to improve and refine their services" (*id.*).

The District Court further found that in fact "the ban on balance billing has had no impact on *average* physician practice income." Instead, its effect is that "in Massachusetts, superior physicians are undercompensated and below-average physicians are overcompensated" (A. 63). In other words, the reduction in some fees accomplished by the ban does not contain medical costs in the aggregate, but merely allocates them among individual physicians in a discriminatory manner that eliminates many of the qualitative benefits of an unrestrained market.

The Reasoning Of the Court of Appeals.

In reversing, the Court of Appeals did not purport to set aside a single one of these findings of fact. Instead, it held that "[w]e disagree with the district court because we do not believe that the facts that it found show an unreasonable restraint of trade" (A. 5). It went on to hold categorically that

the contractual restraints by which Blue Shield substantially regulates the economics of medical practice in Massachusetts are permissible as a matter of law — lawful *per se* — regardless of their coercive nature, regardless of Blue Shield's dominant power in the relevant market, and regardless of the extracontractual anticompetitive effects found by the District Court. In other words, the Court of Appeals has decided that conventional rule of reason analysis is irrelevant to the antitrust legality of a health insurer's contractual regulation of provider fees.

The premise of the Court of Appeals' theory of *per se* lawfulness is strikingly simple:

> "The persuasive power of the district court's analysis disappears * * * once one looks at Blue Shield * * * as itself the purchaser of the doctors' services." (A. 6).
> "The [only] relevant antitrust facts are that Blue Shield pays the bill and seeks to set the amount of the charge. Those facts * * * convince us that Blue Shield's activities here are *like* those of a buyer." (A. 10).

The theory is then developed by abstract deduction. The syllogism proceeds as follows:

> (1) Blue Shield is the purchaser of medical services provided to subscriber patients.
> (2) A purchaser, regardless of its market power, has an unqualified right to set the price at which it will purchase (at least in the absence of below cost pricing by a monopsonist).
> (3) Therefore, Blue Shield has an unqualified right to use its dominant market power to impose contractual fee restraints upon medical services provided to subscriber patients, regardless of the effects on competition in the market for physicians' services.

See A. 7- A. 8; A. 10-A. 14; A. 16. The Court of Appeals found that "*Maricopa* is simply not on point" because it involved a horizontal agreement among physicians and such "agree-

ments by competitors to limit independent decision-making" are categorically different from vertical agreements depriving the same competitors of the power of independent decision-making (A. 18).

The Court of Appeals went on to explain that "three additional circumstances militate strongly" in favor of its approach; although they "do not dictate our result in this case," they "counsel us against" finding antitrust illegality (A. 18-19). These considerations are (1) that "the relevant economic considerations may be very different when low prices, rather than high prices, are at issue" (A. 18); (2) that the subject of medical costs is one "of great complexity where more than solely economic values are at stake" (A. 19); and (3) that "the price system here at issue is one supervised by state regulators," making "strict antitrust scrutiny * * * less likely to be necessary" (*id.*).

Reasons for Granting the Writ

In holding that it is *per se* lawful for health insurers to regulate physicians' fees, the Court of Appeals has decided an important question of antitrust law with great potential impact upon a major segment of the economy. This case presents in its starkest form the question noted but not decided in *Arizona v. Maricopa County Medical Society*, 457 U.S. 332, 353, n.26 (1982) — "whether an insurer may, consistent with the Sherman Act, fix [a maximum fee] schedule and enter into bilateral contracts with individual doctors" imposing the maximum fee schedule upon them.[7]

As we show in the pages that follow, the Court of Appeals' decision does violence to fundamental Sherman Act principles by categorically endorsing this restraint upon the relationship between physicians and their patients without allow-

[7] The importance of this case is reflected by the fact that both the National Blue Cross and Blue Shield Association and the American Medical Association, among others, filed briefs as *amici curiae* in the Court of Appeals.

ing consideration of the effects upon competition and the quality of medical services found in the District Court's rule of reason analysis. Contrary to the Court of Appeals' claim of consistency with cases in other Circuits on similar subjects, the decision below actually conflicts with the reasoning of those cases, which endorse precisely the kind of rule of reason analysis swept aside in this case. By the same token, the issue now presented has not been presented in the health insurance cases recently brought to this Court,[8] much less on a fully developed trial record followed by an extensively (if erroneously) reasoned appellate decision.

Accordingly, certiorari should be granted both to answer the important question left open in *Maricopa* and to correct the Court of Appeals' serious distortion of antitrust principles.

I. The Court of Appeals Has Departed from Fundamental Sherman Act Principles in Holding a Contract Lawful Even Though Conventional Rule of Reason Analysis Discloses That it has Substantial Net Anticompetitive Effects.

Even if the Participating Physician's Agreement were a simple contract of purchase and sale, such a contract is as much subject to rule of reason analysis as any other. Section 1 of the Sherman Act addresses "*[e]very* contract * * * in restraint of trade." The Court of Appeals has not attempted to explain why this language does not include a contract imposed by a "purchaser," particularly where the contract affects the relationship between the "seller" and the actual consumers of the services "purchased" for them.

[8] *Royal Drug Co. v. Group Life & Health Ins. Co.*, 737 F.2d 1433 (5th Cir. 1984), *cert. denied*, 53 U.S.L.W. 3507 (Jan. 15, 1985); *Sausalito Pharmacy, Inc. v. Blue Shield of California*, 677 F.2d 47 (9th Cir.), *cert. denied*, 459 U.S. 1016 (1982).

While this Court has not specifically applied the rule of reason to the price terms of a purchase contract, it has applied it to other terms of such a contract. *Jefferson Parish Hospital District No. 2 v. Hyde,* 104 S. Ct. 1551, 1561 (1984) (when a tying agreement does not rise to the level of a *per se* violation, nonetheless "an antitrust violation can be established * * * by evidence of unreasonable restraint on competition in the relevant market"); see *Fortner Enterprises Inc. v. United States Steel Corp.,* 394 U.S. 495, 500 (1969) (same); *Tampa Electric Co. v. Nashville Coal Co.,* 365 U.S. 320, 335 (1961) (requirements contract). Assuming — as we do here — that Blue Shield's vertical price restraint is not *per se* illegal, there is no apparent reason why it should not remain subject to similar rule of reason analysis. This Court's recent decision in *National Collegiate Athletic Ass'n v. Board of Regents of the University of Oklahoma,* 104 S. Ct. 2948 (1984) (hereafter *"NCAA"*), has made just such an analysis in the case of horizontal price restraints not illegal *per se.*[9]

The Court of Appeals incorrectly relied on several decisions in other Circuits as "upholding" contractual price restraints by health insurers (A. 8-A. 9). In fact, those decisions merely rejected challenges based entirely or largely upon *per se* theories without any significant evidence of effects on competition, and expressly recognized that such contractual schemes would violate the rule of reason if it were "establish[ed] that [they] imposed an unreasonable restraint on competition among [providers]." *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut, Inc.,* 675 F.2d 502, 505, 507 (2d Cir. 1982); see *Pennsylvania Dental Ass'n v. Medical Service Ass'n of Pennsylvania,* 1984-2 Trade Cas. (CCH) ¶ 66,214 at p. 66,876 & n.4 (3d Cir. 1984); *Royal Drug Co. v. Group Life & Health Ins. Co.,* 737

[9] This Court noted in *NCAA* that "[t]he fact that a practice is not categorically unlawful in all or most of its manifestations certainly does not mean that it is universally lawful." 104 S. Ct. at 2965 n.39.

F.2d 1433, 1438-1439 (5th Cir. 1984), *cert. denied*, 53 U.S.L.W. 3507 (Jan. 15, 1985); *Sausalito Pharmacy, Inc. v. Blue Shield of California*, 544 F. Supp. 230, 235, 237 (N.D. Cal. 1981), *aff'd per curiam on district court opinion*, 677 F.2d 47 (9th Cir.), *cert. denied*, 459 U.S. 1016 (1982).[10]

Here, in contrast, the District Court found, on a full trial record, that Blue Shield's contractual fee restrictions unreasonably restrain competition in the market for physicians' services in Massachusetts. Their tendency is not merely to reduce particular physicians' compensation for particular services, but more generally to distort the economics of the physician-patient relationship. Blue Shield restrains not only the "trade" between itself and physicians but also the "trade" between physicians and their patients, with adverse effects upon the normal competitive incentives protected by the Sherman Act and thereby upon the quality of medical care.

Contrary to the Court of Appeals' view (A. 17-A. 18), the District Court properly referred to this Court's restatement of the dangers of maximum price fixing in *Maricopa* as the touchstone for determining that these market effects violate the rule of reason. This Court has recently applied the identical *Maricopa* formulation to rule of reason analysis in *NCAA*, 104

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[10] See also *Travelers Ins. Co. v. Blue Cross of Western Pennsylvania*, 481 F.2d 80, 84 (3rd Cir.), *cert. denied*, 414 U.S. 1093 (1973); *Proctor v. State Farm Mutual Auto Ins. Co.*, 675 F.2d 308, 337-338 (D.C. Cir.), *cert. denied*, 459 U.S. 839 (1982); and *Quality Auto Body, Inc. v. Allstate Ins. Co.*, 660 F.2d 1195, 1203 (7th Cir. 1981), *cert. denied*, 455 U.S. 1020 (1982), none of which involved any prohibition against balance billing.

It is obviously more difficult to show anticompetitive restraints resulting from price restraints on drugs than from fee restraints upon physicians, since drugs are fungible products whose quality is not affected by retail pricing. In contrast, medical services are by their nature heterogeneous and "tailor made." The cases referred to by the Court of Appeals also differ from the present one because of the lack of evidence of economic coercion in those cases. See A. 53-A. 54.

S. Ct. at 2964 n.33, noting that "whether the ultimate finding is the product of a *[per se]* presumption or actual market analysis, the essential inquiry remains the same — whether or not the challenged restraint enhances competition," *id.* at 2962. This criterion is no less applicable to vertical restraints, for "vertical control destroys horizontal competition as effectively as if [the persons whose prices are controlled] 'formed a combination and endeavored to establish the same restrictions . . . by agreement with each other.'" *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 103 (1980) (quoting from *Dr. Miles Medical Co. v. John D. Park & Sons Co.*, 220 U.S. 373, 408 (1911)).[11] Indeed, the *Maricopa* formulation was expressly derived from, and largely similar to, that in *Albrecht v. Herald Co.*, 390 U.S. 145, 152-153 (1968), which held vertical maximum price fixing unlawful. See 457 U.S. at 347.

The Court of Appeals has held that competitive harms that would normally condemn a contract under the rule of reason are irrelevant because Blue Shield is a "purchaser," *i.e.*, that there are no conceivable circumstances under which an insurer's contractual regulation of physicians' fees, or the price terms of any purchase contract, could violate the antitrust laws. This stark proposition conflicts with the antitrust principles previously established by this Court and with other courts of appeals' views of the proper mode of analysis of health provider fee restraints, and should therefore be reviewed by this Court.

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[11] The District Court appropriately treated Blue Shield's coercive market power and its non-coverage of services by physicians who have not agreed to Blue Shield's terms *not* as grounds for liability in themselves, but rather as attributes of the market environment in the light of which the competitive effects of the ban on balance billing should be evaluted under the rule of reason.

II. The Court of Appeals' Treatment of Health Insurers as Sole Purchasers of Physicians' Services Distorts the Relevant Economic Relationships and Ignores the Interests of Insurance Beneficiaries in a Competitive Market.

The sterile syllogism that the Court of Appeals substituted for normal rule of reason analysis depends on the premise that the Participating Physician's Agreement is simply a contract by which Blue Shield purchases medical services, as well as the corollary notion that a purchaser's desire to pay as little as possible overrides all other considerations. Even if the latter notion were correct in the case of a conventional purchaser of goods and services, it is a serious question whether an insurance indemnitor such as Blue Shield can be equated with a true purchaser in this respect.

Health insurers do have some of the attributes of a purchaser in their relationship to providers, growing out of the obvious fact that they pay at least a large portion of the bill. That is, in part, the reason why provider contracts are not elements of the "business of insurance" exempted by the McCarran-Ferguson Act. See *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 214 (1979). It is also the reason why the District Court, following precedents in other Circuits, held that Blue Shield's price restraints are not illegal *per se*, a holding that we do not challenge here. See 542 F. Supp. at 795-796; *e.g.*, *Medical Arts Pharmacy of Stamford, Inc.*, *supra*, 675 F.2d at 505.

It is equally obvious, contrary to the Court of Appeals' premise, that Blue Shield does not have *all* of the attributes of a conventional purchaser of goods and services because it is not the consumer of what it pays for. In all respects other than price alone, the normal interests of a purchaser reside in the third party to this three-sided transaction, the individual

subscriber-patient for whose medical services Blue Shield pays. It is the patient, not Blue Shield, who is directly concerned with the qualitative aspects of medical care that the District Court found impaired by restraint of competition among physicians. Whatever a true purchaser might be allowed to do, it is an entirely different question whether the financial interest of an insurer such as Blue Shield may override its *subscribers'* interests in the qualitative benefits of competition among physicians. The Court of Appeals' unqualified affirmative answer to this question is a significant new departure in antitrust doctrine.[12]

The Court of Appeals' effort to analogize Blue Shield's pervasive regulation of the price terms of physician-patient relationships to a father's specification of the price for toys selected by his son or a landlord's contract with a painter (A. 8) is fallacious. That such homely situations instinctively seem lawful is no basis for inferring a categorical antitrust principle that "he who pays the piper may call the tune." Rather, it simply reflects the fact that such atomistic transactions in fungible products or services are unlikely to affect competition. Here, in contrast, we are concerned with a coercively imposed restraint on price competition with factually demonstrated substantial effects on competition in the market and on the quality of the services available to the actual con-

[12] No other court of appeals has adopted the stark "purchaser's rights" reasoning on which the decision below is based. For example, *Medical Arts Pharmacy of Stamford, Inc., supra,* expressly noted that health provider agreements "are not precisely between seller and purchaser (but between seller and indemnitor)," and are therefore "*sui generis*" — not *per se* unlawful insofar as they fix prices but remaining subject to rule of reason analysis. 675 F.2d at 506. *Pennsylvania Dental Ass'n, supra,* similarly observed that there is a "two-sided buyer composed of the insurer and the subscriber." 1984-2 Trade Cas. (CCH) at p. 66,877. In contrast, the syllogistic reasoning of the Court of Appeals is an example of the kind of formalism, divorced from any attention to real effects in the marketplace, that this Court condemned in *Simpson v. Union Oil Co.*, 377 U.S. 13 (1964); see also *NCAA*, 104 S. Ct. at 2967.

sumers. The Court of Appeals' holding that such a restraint is lawful *per se* raises an important antitrust question requiring review by this Court.

III. The Unique Characteristics of Health Insurance Do Not "Counsel Against" Rigorous Application of the Antitrust Laws, But Rather Enhance the Importance of the Issue Raised by the Court of Appeals' Decision.

The "additional circumstances" that the Court of Appeals found to "militate strongly" against finding a violation (A. 18-A. 20) reveal a result-orientation inconsistent with antitrust jurisprudence. The Court of Appeals' desire to protect a mechanism believed to lower the price of medical care is understandable, but it flouts this Court's repeated "refus[al] to tolerate manifestly anticompetitive conduct simply because the health care industry is involved,"[13] as well as the more general principles that neither price reductions[14] nor presumed social benefits[15] can justify restraints upon competition.

The Court of Appeals' intuitive notion that the ban on balance billing reduces medical costs is, in fact, negated by the District Court's undisturbed finding that the ban has no effect at all on *aggregate* fees (as distinguished from their allocation among individual physicians). And the assertion that "strict antitrust scrutiny" has diminished importance because "the price system here at issue is one supervised by state regulators" (A. 19) is directly contradicted by the record. In fact, the parties stipulated that there is no

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[13] *Jefferson Parish Hospital District No. 2 v. Hyde*, *supra*, 104 S. Ct. at 1565 n.42 (1984), citing *Maricopa* and other cases.

[14] *Maricopa*, 457 U.S. at 348, 352 n.25; *Albrecht v. Herald Co.*, *supra*, 390 U.S. at 152-153.

[15] *E.g.*, *NCAA*, 104 S. Ct. at 2969; *National Society of Professional Engineers v. United States*, 435 U.S. 679 (1978).

regulatory oversight over the maximum fees for particular categories of medical services, which Blue Shield determines in its sole discretion.[16]

The magnitude of the antitrust issue presented here is enhanced, not diminished, by the fact that the subject matter is purported containment of medical costs. This Court's previous decisions in this area (particularly *Royal Drug* and *Maricopa*) have recognized the need for a clear delineation of the extent to which contractual regulation — as distinguished from possible governmental regulation -- is permitted under the Sherman Act. If the Court of Appeals' decision stands, it will categorically authorize such private regulation by powerful health insurers such as Blue Shield. Whether such a blanket authorization is consistent with the antitrust laws is an important question that should be settled by this Court.

Conclusion

For the foregoing reasons, certiorari should be granted.

Respectfully submitted,

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February 1985

[16] See ¶ 42 of the Stipulation of Facts appearing at pp. 102-103 of the joint appendix in the Court of Appeals.

AA

APPENDICES

Appendix A

United States Court of Appeals for the First Circuit

No. 84-1241

JAMES P. KARTELL, M.D., ET. AL.,
Plaintiffs, Appellees,

v.

BLUE SHIELD OF MASSACHUSETTS, INC.,
Defendant, Appellant.

No. 84-1290

JAMES P. KARTELL, M.D., ET. AL.,
Plaintiffs, Appellees,

v.

BLUE SHIELD OF MASSACHUSETTS, INC., ET AL.,
Defendants, Appellees.

MASSACHUSETTS MEDICAL SOCIETY, ET AL.,
Intervenors/Plaintiffs, Appellants.

No. 84-1303

JAMES P. KARTELL, M.D., ET. AL.,
Plaintiffs, Appellees,

v.

BLUE SHIELD OF MASSACHUSETTS, INC., ET AL.,
Defendants, Appellees.

COMMISSIONER OF INSURANCE,
Intervenor/Defendant, Appellant.

CROSS-APPEALS FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

[Hon. Andrew A. Caffrey, *U.S. District Judge*]

Before
Campbell, *Chief Judge,*
Cowen,* *Senior Circuit Judge,*
and Breyer, *Circuit Judge.*

Daniel O. Mahoney, with whom *Douglas H. Wilkins, Arthur P. Kreiger, Palmer & Dodge,* and *Reginald H. Howe,* were on brief, for Blue Shield of Massachusetts, Inc., et al.

Helen E. Witt, James W. Rankin, Jack A. Rovner, Kirkland & Ellis, Marvin C. Reiter, Mary Ader, on brief, for Blue Cross and Blue Shield Association, amicus curiae.

John R. Phillips, and *Richard B. Rogers,* were on brief, for Ford Motor Company, amicus curiae.

H. Reed Witherby, Assistant Attorney General, Government Bureau, with whom *Francis X. Bellotti,* Attorney General, and *Donna Arzt,* Assistant Attorney General, Public Protection Bureau, were on brief, for Massachusetts Commissioner of Insurance.

Thayer Fremont-Smith, with whom *Kenneth Laurence, Lee T. Gesmer, Michael K. Loucks,* and *Choate, Hall & Stewart,* were on brief, for Massachusetts Medical Society, et al.

Kirk B. Johnson, with whom, *B.J. Anderson, American Medical Association, Newton N. Minow, Jack R. Bierig, Jeffrey R. Tone, James C. Dechene,* and *Sidley & Austin,* were on brief, for American Medical Association, amicus curiae.

Catherine W. Hantzis on brief for Consumer Health Advocates, Inc., amicus curiae.

James van R. Springer, with whom *Dickstein, Shapiro & Morin, Stanley V. Ragalevsky, Christopher E. Nolin,* and *Warner & Stackpole,* were on brief, for James P. Kartell, M.D., et al.

November 28, 1984

BREYER, *Circuit Judge.* Blue Shield pays doctors for treating patients who are Blue Shield health insurance subscribers, but only if each doctor promises not to make any additional charge to the subscriber. The basic issue in this case is whether this Blue Shield practice — called a "ban on balance billing" — violates either Sherman Act § 1 forbidding agreements "in restraint of trade," 15 U.S.C. § 1, or Sherman Act § 2 forbidding "monopolization" and "attempts to monopolize," *id.* § 2. The district court held that the practice constituted an unreasonable restraint of trade in violation of section 1. We conclude that the practice does not violate either section of the Sherman Act; and we reverse the district court.

As the district court noted, the relevant facts are "not . . . generally . . . disputed." Blue Shield provides health insurance for physician services while its sister, Blue Cross, insured against hospital costs. The consumers of Blue Shield insurance, at least those who buy "full service" prepaid medical benefits, can see any "participating doctor," *i.e.*, a doctor who has entered into a standard Participating Physician's Agreement with Blue Shield. (If a doctor has not signed the Agreement, Blue Shield will reimburse him only if he provides emergency or out-of-state services.) Under the standard agreement, a participating doctor promises to accept as payment in full an amount determined by Blue Shield's "usual and customary charge" method of compensation. The district court found that the method has evolved, through the use of various 'capping' devices, towards payment of a 'fixed fee,' determined by Blue Shield, for each particular type of service. Blue Shield pays this amount directly to the doctor; the patient pays nothing out of his own pocket and therefore receives no reimbursement.

The district court also found that Blue Shield provides some form of health insurance to about 56 percent of the Massachusetts population. (About 45 percent has coverage carrying a 'balance billing' ban.) If one subtracts from the total population universe those Massachusetts residents who rely on government sponsored health care (*e.g.*, Medicare or Medicaid), then Blue Shield (and Blue Cross) provide insurance coverage for about 74 percent of the rest, namely those Massachusetts residents who *privately* insure against health costs. (About 23 percent of that group have coverage with commercial insurers; and about 4 percent subscribe to Health Maintenance Organizations.) Virtually all practicing doctors agree to take Blue Shield subscribers as patients and to participate in its fee plan. Blue Shield payments made under that plan account for about 13 to 14 percent of all "physician practice revenue."

The district court found that, because of the large number of subscribers, doctors are under "heavy economic pressure" to take them as patients and to agree to Blue Shield's system for charging the cost of their care. The court believed that the effect of this payment system, when combined with Blue Shield's size and buying power, was to produce an unreasonably rigid and unjustifiably low set of prices. In the court's view, the fact that doctors cannot charge Blue Shield subscribers more than the Blue Shield payment-schedule amounts interferes with the doctors' freedom to set higher prices for more expensive services and discourages them from developing and offering patients more expensive (and perhaps qualitatively better) services. For these and related reasons, the district court held that Blue Shield's ban on 'balance billing' unreasonably restrains trade, and thereby violates Sherman Act § 1. Blue Shield appeals from this holding. The plaintiff doctors cross-appeal from other rulings of the district court in Blue Shield's favor.

On these appeals, the parties raise a host of issues not directly related to the antitrust merits, including the claim that a recently enacted state law, Mass. St. 1984, ch. 192, § 1, renders the case moot by immunizing Blue Shield's "balance billing ban" from the reach of the antitrust laws. The 'mootness' issue, however, is not a simple one. And even if we accept the mootness claim, the new statute may not immunize the defendants from treble-damage liability for past conduct. In view of these legal and practical problems, and the fact that this case has been pending in the federal courts for more than seven years, we believe it simpler and more appropriate to proceed directly to the antitrust merits, which, on our view of the case, are dispositive.

I

We disagree with the district court because we do not believe that the facts that it found show an unreasonable re-

straint of trade. We can best explain our reasons by first discussing the basic antitrust issue in general terms, then turning to the specific, detailed arguments advanced by the parties, and finally noting several special reasons here that militate against a finding of liability.

A

We disagree with the district court's finding of "restraint." To find an unlawful restraint, one would have to look at Blue Shield as if it were a 'third force,' intervening in the marketplace in a manner that prevents willing buyers and sellers from independently coming together to strike price/quality bargains. Antitrust law typically frowns upon behavior that impedes the striking of such independent bargains. The persuasive power of the district court's analysis disappears, however, once one looks at Blue Shield, not as an inhibitory 'third force,' but as itself the purchaser of the doctors' services. *See Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 214 (1979) (direct reimbursement to participating pharmacies for subscribers' drugs "merely [an] arrangement[ ] for the purchase of goods and services by Blue Shield"). Antitrust law rarely stops the buyer of a service from trying to determine the price or characteristics of the product that will be sold. Thus, the more closely Blue Shield's activities resemble, in essence, those of a purchaser, the less likely that they are unlawful.

Several circuits have held in antitrust cases that insurer activity closely analogous to that present here amounts to purchasing, albeit for the account of others. And, they have held that an insurer may lawfully engage in such buying of goods and services needed to make the insured whole. The Second Circuit has held lawful a Blue Shield plan requiring pharmacies to accept Blue Shield reimbursement as full payment for drugs they supply to Blue Shield subscribers. *Medical Arts*

Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut, Inc., 675 F.2d 502 (2d Cir. 1982). The Third Circuit has allowed a hospital cost insurer (Blue Cross) to reimburse hospitals directly (and apparently completely) for services to subscribers. *Travelers Insurance Co. v. Blue Cross of Western Pennsylvania*, 481 F.2d 80 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973). The Seventh Circuit has permitted auto insurance companies to furnish direct reimbursement to repair shops as payment for the repair services provided to policyholders. *Quality Auto Body, Inc. v. Allstate Insurance Co.*, 660 F.2d 1195 (7th Cir. 1981), *cert. denied*, 455 U.S. 1020 (1982).

At the same time, the facts before us are unlike those in cases where courts have forbidden an 'organization' to buy a good or service — cases in which the buyer was typically a 'sham' organization seeking only to combine otherwise independent buyers in order to suppress their otherwise competitive instinct to bid up price. *Mandeville Island Farms, Inc. v. American Crystal Sugar Co.*, 334 U.S. 219, 235 (1948) (horizontal price-fixing by purchasers held *per se* illegal); *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940) (same); *National Macaroni Manufacturers Association v. Federal Trade Commission*, 345 F.2d 421 (7th Cir. 1965) (competitors in trade association fixing quantity of scarce component to be used in macaroni held *per se* illegal). No one here claims that Blue Shield is such a 'sham' organization or anything other than a legitimate, independent medical cost insurer. *But, cf. Virginia Academy of Clinical Psychologists v. Blue Shield of Virgina*, 624 F.2d 476 (4th Cir. 1980) (Blue Shield found to be a combination, not of policyholders, but of *physicians*), *cert. denied*, 450 U.S. 916 (1981).

Once one accepts the fact that, from a commercial perspective, Blue Shield in essence 'buys' medical services for the account of others, the reasoning underlying the Second, Third,

and Seventh Circuit views indicates that the ban on balance billing is permissible. To understand that reasoning, consider some highly simplified examples. Suppose a father buys toys for his son — toys the son picks out. Or suppose a landlord hires a painter to paint his tenant's apartment, to the tenant's specifications. Is it not obviously lawful for the father (the landlord) to make clear to the seller that the father (the landlord) is in charge and will pay the bill? Why can he not then forbid the seller to charge the child (the tenant) anything over and above what the father (the landlord) pays — at least if the seller wants the buyer's business? To bring the example closer to home, suppose that a large manufacturing company hires doctors to treat its employees. Can it not insist that its doctors not charge those employees an additional sum over and above what the company agrees to pay them to do the job? In each of these instances, to refuse to allow the condition would disable the buyer from holding the seller to the price of the contract. Yet, if it is lawful for the buyer to buy for the third party in the first place, how can it be unlawful to bargain for a price term that will stick?

Given this argument, it is not surprising the courts have unanimously upheld contracts analogous in various degrees to the one at issue here — contracts in which those who directly provide goods or services to insureds have agreed to cap or forego completely additional charges to those insureds in return for direct payment by the insurer. In addition to *Medical Arts* and *Travelers, supra*, see *Royal Drug Co. v. Group Life and Health Ins. Co.*, 737 F.2d 1433 (8th Cir. 1984) ($2 cap on balance billing for drugs); *Webster County Memorial Hospital, Inc. v. United Mine Workers*, 536 F.2d 419 (D.C. Cir. 1976) (hospital agrees to ban on balance billing in exchange for direct payment by union trust fund); *Proctor v. State Farm Mutual Auto Insurance Co.*, 675 F.2d 308, 337 (D.C. Cir. 1982) (auto repair shops agree to provide repairs at rate set by insurance company), *cert. denied*, 459 U.S. 839

(1982); *Sausalito Pharmacy, Inc. v. Blue Shield of California*, 544 F. Supp. 230 (N.D. Cal. 1981), *aff'd per curiam*, 677 F.2d 47 (9th Cir.) (cap on balance billing by participating pharmacies), *cert. denied*, 459 U.S. 1016 (1982); *Feldman v. Health Care Service Corp.*, 562 F. Supp. 941 (N.D. Ill. 1982) (same); *Pennsylvania Dental Association v. Medical Service Association of Pennsylvania*, 574 F. Supp. 457 (M.D. Pa. (1983), *aff'd* No. 84-5004 (3rd Cir. Oct. 1, 1984) (ban on balance billing for dental services); *Michigan State Podiatry Association v. Blue Cross and Blue Shield of Michigan*, 1982-2 Trade Cas. (CCH) ¶ 64,801 (E.D. Mich. 1982); *Blue Cross and Blue Shield of Michigan, Inc. v. Michigan Association of Psychotherapy Clinics, Inc.*, 1980-2 Trade Cas. (CCH) ¶ 63,351 (E.D. Mich. 1980); *Davidowitz v. San Diego County Dental Society*, 1983-1 Trade Cas. (CCH) ¶ 65,231 (S.D. Cal. 1983). Scholarly commentators believe that these cases were correctly decided. *See, e.g.*, P. Areeda, Antitrust Analysis 530-31 (1981) ("[I]t is difficult to see what could make [such an] arrangement anticompetitive"). *See also* Comment, 75 Nw. U. L. Rev. 506 (1980).

Two arguments might be made in an effort to distinguish these cases. First, the doctors may claim that Blue Shield is not, in essence, a buyer. Traditionally, doctors have opposed financial arrangements that involved the 'selling' of their services to anyone but the patient. *See* Comment, 63 Yale L.J. 938, 978-80 (1954). And medical associations in the past sometimes have argued that selling services to third parties or related 'corporate practice' might interfere with the absolute ethical obligation that a doctor owes to the patient. *Id.*, (citing, *e.g.*, AMA, Principles of Medical Ethics, ch. 3, art. 5, § 4). Medical associations have not, however, opposed reimbursement by third party insurers, such as Blue Shield, a fact that arguably suggests an important distinction between 'insurance reimbursement' and 'purchasing.'

In our view, however, any such distinction is irrelevant for antitrust purposes. The relevant antitrust facts are that Blue Shield pays the bill and seeks to set the amount of the charge. Those facts led other courts in similar circumstances to treat insurers as if they were 'buyers.' The same facts convince us that Blue Shield's activities here are *like* those of a buyer. Whether for ethical, medical, or related professional purposes Blue Shield is, or is not, considered a buyer is beside the point. We here consider only one specific argued application of the antitrust laws and we do not suggest how Blue Shield ought to be characterized in any other context.

Second, the doctors seek to distinguish these precedents by pointing to an important district court finding either not present or not discussed in depth in these other cases. The district court here found that Blue Shield is a buyer with significant 'market power' — *i.e.*, the power to force prices below the level that a freely competitive market would otherwise set. They argue that Blue Shield's 'market power' makes a significant difference. We do not agree.

At the outset, we note that Blue Shield disputes the existence of significant 'market power.' It points out that the district court relied heavily upon participation by 99 percent of all Massachusetts doctors in Blue Shield's program, as "prov[ing] ... Blue Shield's economic power." But, Blue Shield says, this by itself proves little. Participating in Blue Shield's program does not stop doctors from taking other patients or from charging those other patients what they like. As long as Blue Shield's rates are even marginally remunerative, 99 percent of all doctors might sign up with Blue Shield if it had only ten policyholders or ten thousand instead of several million.

Blue Shield adds that the record does not prove the existence of the single harm most likely to accompany the existence of market power on the buying side of the market, namely lower seller output. *See* P. Areeda, *supra* at 343 n.20;

R. Posner, *Antitrust*, 5-14, 91-3 (1974). Indeed, here the district court found that the supply of doctors in Massachusetts has "increased steadily during the past decade." Blue Shield also claims that whatever power it possesses arises from its ability as an 'expert' to prevent doctors from charging unknowledgeable patients *more* than a free (and informed) market price. *See generally* Comment, 75 Nw. U. L. Rev., *supra*.

On the other hand, several doctors testified that low prices discouraged them from introducing new highly desirable medical techniques. And, they argue that fully informed patients would have wanted to pay more for those techniques had they been allowed to do so.

To resolve this argument about the existence of market power — an issue hotly debated by the expert economists who testified at trial — would force us to evaluate a record that the district court described as "two competing mountains of mostly meaningless papers." Rather than do so, we shall assume that Blue Shield possesses significant market power. We shall also assume, but purely for the sake of argument, that Blue Shield uses that power to obtain 'lower than competitive' prices.

We next ask whether Blue Shield's assumed market power makes a significant legal difference. As a matter of pure logic, to distinguish the examples previously mentioned one must accept at least one of the following three propositions: One must believe either (1) that the law forbids a buyer with market power to bargain for 'uncompetitive' or 'unreasonable' prices, or (2) that such a buyer cannot buy for the account of others, or (3) that there is some relevant difference between obtaining such price for oneself and obtaining that price for others for whom one can lawfully buy. In our view, each of these propositions is false, as a matter either of law or of logic.

First, the antitrust laws interfere with a firm's freedom to set even uncompetitive prices only in special circumstances, where, for example, a price is below incremental cost. Such a "predatory" price harms competitors, cannot be maintained, and is unlikely to provide consumers benefits. *Barry Wright Corp. v. ITT Grinnell Corp.*, 724 F.2d 227 (1st Cir. 1983). *Cf. United States v. Aluminum Co. of America*, 148 F.2d 416, 437-38 (2nd Cir. 1945) (vertically-integrated aluminum monopolist can both charge an unreasonably high price for ingots *and* set a fabricated product price too low for competing fabricators to survive). Ordinarily, however, even a monopolist is free to exploit whatever market power it may possess when that exploitation takes the form of charging uncompetitive prices. As Professor Areeda puts it, "Mere monopoly pricing is not a violation of the Sherman Act." P. Areeda, *Antitrust Law* § 710 (Supp. 1982). The Second Circuit has recently held that "more than monopoly power is necessary to make the charging of a noncompetitive price unlawful." *Berkey Photo, Inc. v. Eastman Kodak Co.*, 603 F.2d 263, 297 (2nd Cir. 1979), *cert. denied*, 444 U.S. 1093 (1980). *Cf. Monsanto Co. v. Spray-Rite Service Corp.*, 104 S. Ct. 1464 (1984).

The reasons underlying this principle include a judicial reluctance to deprive the lawful monopolist (say a patent monopolist) of its lawful rewards, and a judicial recognition of the practical difficulties of determining what is a "reasonable," or "competitive," price. *See* 2 P. Areeda & D. Turner, *Antitrust Law* §§ 512-14 (1978); 3 *id.* ¶ 710; R. Bork, *The Antitrust Paradox*, 125-29 (1978). As the Supreme Court stated in a different context,

> The reasonable price fixed today may through economic and business changes become the unreasonable price of tomorrow. . . . [W]e should hesitate to adopt a construction making the difference between legal and illegal conduct in the field of business relations depend upon so un-

> certain a test as whether prices are reasonable — a determination which can be satisfactorily made only after a complete survey of our economic organizations and a choice between rival philosophies.

United States v. Trenton Potteries Co., 273 U.S. 392, 397-98 (1927). Thus, where a monopoly is unlawful, antitrust courts typically seek to change the market's structure, "to break up or render impotent the monopoly power which violates the Act." *United States v. Aluminum Co. of America*, 91 F. Supp. 333, 334 (S.D.N.Y. 1950) (citing *Schine Chain Theatres, Inc. v. United States*, 334 U.S. 110, 128-29 (1948)). *See also Standard Oil Co. of New Jersey v. United States*, 221 U.S. 1 (1911). Courts only rarely try to supervise the price bargain directly. 3 P. Areeda & D. Turner, *supra*, ¶ 710 n.2. *Cf. United States v. Glaxo Group Ltd.*, 410 U.S. 52 (1973) (ordering compulsory patent licensing "at reasonable charges"). And, where monopoly power is regulated, the regulator, not the court, bears the burden of determining whether prices are reasonable. *See, e.g.*, Mass. Gen. Laws ch. 164, §§ 93-94 (state regulation of gas and electric rates).

The district court did not suggest here that the prices subject to the 'balance billing' ban were 'predatory.' Nor (with one possible exception, see pp. 30-32) do the parties point to evidence of any price below anyone's 'incremental cost.' *Cf. Barry Wright Corp. v. ITT Grinnell Corp.*, *supra*. Rather, the district court suggested that Blue Shield's prices were 'uncompetitively low,' 'unreasonably low,' lower than the doctors might have charged to individual patients lacking market power. That is to say, Blue Shield obtained prices that reflected its market power. For the reasons just mentioned then, if Blue Shield had simply purchased those services for itself, the prices paid, in and of themselves, would not have amounted to a violation of the antitrust laws. *Berkey Photo, Inc. v. Eastman Kodak Co.*, *supra*; 3 P. Areeda & D. Turner, *supra*, ¶ 710.

Second, as we previously mentioned, there is no law forbidding a legitimate insurance company from itself buying the goods or services needed to make its customer whole. The cases that we have cited are unanimous in allowing such arrangements. The rising costs of medical care, the possibility that patients cannot readily evaluate (as competitive buyers) competing offers of medical service, the desirability of lowering insurance costs and premiums, the availability of state regulation to prevent abuse — all convince us that we ought not create new potentially far-reaching law on the subject. And, the parties have not seriously argued to the contrary.

Third, to reject the first two propositions is, as a matter of logic, to reject the third. If it is lawful for a monopoly buyer to buy for the account of another, how can it be unlawful for him to insist that no additional charge be made to that other? To hold to the contrary is, in practice, to deny the buyer the right to buy for others, for the seller would then be free to obtain a different price from those others by threatening to withhold the service. This reasoning seems sound whether or not the buyer has 'market power.'

In essence, then, the lawfulness of the term in question stems from the fact that it is an essential part of the price bargain between buyer and seller. Whether or not that price bargain is, in fact, reasonable is, legally speaking, beside the point, even in the case of a monopolist. As Blue Shield stresses in its brief, health maintenance organizations, independent practice associations, and preferred provider organizations all routinely agree with doctors that the doctors will accept payment from the plan as payment in full for services rendered to subscribers. We can find no relevant analytical distinction between this type of purchasing decision and the practice before us — even on the assumption that Blue Shield possesses market power.

B

We now consider more closely the specific arguments raised by the district court and the parties to show that Blue Shield's 'balance billing ban' is anticompetitive in practice. The Rodkey plaintiffs' brief sets forth in summary form the following allegedly harmful effects of the ban:

(1) Price competition among physicians for services covered by Blue Shield's service benefit policies is "virtually eliminated."

(2) Doctor's prices have tended to cluster around Blue Shield's "maximum price levels."

(3) Doctors wanting to compete by offering innovative or 'premium' services are inhibited from doing so because Blue Shield's pricing structure assumes that physicians' services are fungible and mandates the same price ceilings for virtually all physicians.

(4) Doctors just entering practice are discouraged from doing so by particularly low levels of Blue Shield reimbursement.

(5) Blue Shield's low prices lead doctors to charge higher prices to others.

(6) Blue Shield discourages doctors from charging others low prices by insisting that its subscribers be given the benefit of any such low prices.

(7) Blue Shield's pricing system discourages doctors from trying out more expensive services that could bring about lower total medical costs, *e.g.*, a "colonoscopy with polypectomy," an expensive service that is nonetheless cheaper than the surgery that would otherwise be needed to cure the patient.

(8) Blue Shield, by reason of its pricing practices, has been able to attract more subscribers, extending its "competitive edge" over other health insurers, and increasing its dominance in the health insurance business.

The first seven of these arguments attack the price term in the agreement between Blue Shield and the doctors. To argue that Blue Shield's pricing system is insufficiently sensitive to service differences, or that it encourages high costs, or does not give the patients what they really need, or to claim that the buyer is making a bad decision is like arguing that the buyer of a fleet of taxicabs ought to buy several different models, or allow the seller to vary color or horsepower or gearshift because doing so either will better satisfy those passengers who use the fleet's services, or will in the long run encourage quality and innovation in automobile manufacture. The short — and conclusive — answer to these arguments is that normally the choice of what to seek to buy and what to offer to pay is the buyer's. And, even if the buyer has monopoly power, an antitrust court (which might, in appropriate circumstances, restructure the market) will not interfere with a buyer's (nonpredatory) determination of price.

Thus, the arguments that Blue Shield's payments for doctors' services are "too low" are disposed of by our discussion at pp. 16-18 [A. 12-A. 13] *supra*. A legitimate buyer is entitled to use its market power to keep prices down. The claim that Blue Shield's price scheme is "too rigid" because it ignores qualitative differences among physicians is properly addressed to Blue Shield or to a regulator, not to a court. There is no suggestion that Blue Shield's fee schedule reflects, for example, an effort by, say, one group of doctors to stop other doctors from competing with them. *Cf. Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia, supra.* Here Blue Shield and the doctors "sit on opposite sides of the bargaining table," *Royal Drug Co. v. Group Life & Health Insurance Co.*, 737 F.2d at 1438. And Blue Shield seems simply to be acting "as every rational enterprise does, *i.e.*, [to] get the best deal possible," *Travelers Insurance Co. v. Blue Cross of Western Pennsylvania*, 481 F.2d at 84. The first seven adverse consequences to which appellees point are the result of this unilateral behavior.

Plaintiffs' eighth argument focuses on the health insurance business: Blue Shield's 'ban on balance billing,' by attracting more subscribers, augments its share of the health insurance business, thereby enabling it to secure still lower doctor charges. This argument, however, comes down to saying that Blue Shield can attract more subscribers because it can charge them less. If Blue Shield is free to insist upon a lower doctor charge, it should be free to pass those savings along to its subscribers in the form of lower prices. This conclusion does not rest upon a judgment about the reasonableness of the doctor charge. A monopolist who charges his customers a high price is free to pay his suppliers more, thereby attracting higher quality raw materials. Considered in and of itself, higher quality, like lower prices, is good — even if it helps the monopolist maintain his market power through "superior skill, foresight and industry." *See United States v. Aluminum Co. of America,* 148 F.2d at 429.

Finally, the district court rested its decision in large part upon the Supreme Court's recent case, *Arizona v. Maricopa County Medical Society,* 457 U.S. 332 (1982). *Maricopa,* however, involved a *horizontal* agreement among competing doctors about what to charge. A horizontal argeement among competitors is typically unlawful because the competitors prevent themselves from making *independent* decisions about the terms as to which they will bargain. Competitors cannot *agree,* for example, to insist that their contracts with sellers contain arbitration clauses, even though each individual competitor can make up his own mind to insist upon such a term in any, or all, of his contracts. *United States v. First National Pictures, Inc.,* 282 U.S 44 (1930); *Paramount Famous Lasky Corp. v. United States,* 282 U.S. 30 (1930). The unlawfulness of the agreement does not necessarily depend upon the undesirability of the contractual term as to which competitors agree not to compete.

The district court saw a similarity between the horizontal agreement cases and this one in the fact that Blue Shield can extract an "uncompetitive price" from doctors while the *Maricopa* court feared that "price-fixing" by competitors might bring about uncompetitive prices. But, the antitrust problems at issue when a single firm sets a price — whether, when, and how courts can identify and control an individual exercise of alleged market power — are very different from those associated with agreements by competitors to limit independent decision-making. A decision about the latter is not strong precedent for a case involving only the former. *Maricopa* is simply not on point. Nor, for similar reasons, is *National Collegiate Athletic Association v. Board of Regents*, 52 U.S.L.W. 4928 (U.S. June 27, 1984), another "horizontal agreement" case cited by the doctors.

C

Three additional circumstances militate strongly here against any effort by an antitrust court to supervise the Blue Shield/physician price bargain. These three considerations convince us to apply mainstream antitrust doctrine, which allows a buyer or seller freedom to bargain for price, rather than to seek analogies with more unusual cases that do not.

First, the prices at issue here are low prices, not high prices. *See* Comment, 75 Nw. L. Rev. at 522-23. Of course, a buyer, as well as a seller, can possess significant market power; and courts have held that *agreements* to fix prices — whether maximum or minimum — are unlawful. *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211 (1951); *Albrecht v. Herald Co.*, 390 U.S. 145 (1968). Nonetheless, the Congress that enacted the Sherman Act saw it as a way of protecting consumers against prices that were too *high*, not too low. *See*, R. Bork, *supra*, at 61-2. And, the relevant economic considerations may be very different when low

prices, rather than high prices, are at issue. These facts suggest that courts at least should be cautious — reluctant to condemn too speedily — an arrangement that, on its face, appears to bring low price benefits to the consumer. *See Barry Wright Corp. v. ITT Grinnell Corp.*, 724 F.2d at 231-34.

Second, the subject matter of the present agreement — medical costs — is an area of great complexity where more than solely economic values are at stake. How to provide affordable, high quality medical care is much debated. And, many different solutions — ranging from stricter regulation to greater reliance on competing service organizations — have been proposed. *See* Clark, "Why Does Health Care Regulation Fail?" 41 Md. L. Rev. 1 (1981); A. Enthovin, *Health Plan* (1980). This fact, too, warrants judicial hesitancy to interfere.

Third, the price system here at issue is one supervised by state regulators. See *Kartell v. Blue Shield of Massachusetts, Inc.*, 384 Mass. 409, 422, 425 N.E.2d 313 (1981). While that fact does not automatically carry with it antitrust immunity, *see Cantor v. Detroit Edison Co.*, 428 U.S. 579 (1976), it suggests that strict antitrust scrutiny is less likely to be necessary to prevent the unwarranted exercise of monopoly power. Of course, administrative regulation is a highly imperfect process. But, regulation by judicial decree is not necessarily preferable.

These general considerations do not dictate our result in this case. They do, however, counsel us against departing from present law or extending it to authorize increased judicial supervision of the buyer/seller price bargain. Like the court in *Feldman v. Health Care Corp.*, we see "no need to blaze new trails," 562 F. Supp. at 946. Without such pioneering, we do not believe the antitrust laws forbid Blue Shield's 'balance billing' practice. Contrary to the district court's conclusion, the practice does not constitute an unreasonable restraint of trade. And, the same reasons that lead us to this

conclusion also lead us to agree with the district court that the practice does not constitute monopolization or an attempt to monopolize. *See* 3 P. Areeda & D. Turner, *supra*, ¶ 626 at 83.

III

We turn now to four issues that the plaintiff doctors raise in their cross-appeal from other rulings of the district court — rulings that dismissed various parts of their case against Blue Shield (and against Blue Cross, Blue Shield's sister organization). The fact that we have found Blue Shield's ban on balance billing to be lawful simplifies the issues on the cross-appeal and virtually determines an outcome in defendants' favor.

First, the doctors argue that the district court wrongly dismissed their claim that Blue Shield's refusal to reimburse nonparticipating doctors (except for emergency or out-of-state services) violated the antitrust law. The district court found that Blue Shield's actions were immunized from antitrust attack by a prong of the "state action" doctrine which removes actions required (or forbidden) by state laws from the scope of the federal antitrust laws. *See Hoover v. Ronwin*, 52 U.S.L.W. 4535 (U.S. May 14, 1984). The Massachusetts Supreme Judicial Court has held that state law, namely Mass. Gen. Laws ch. 176B, § 7 prohibits Blue Shield from generally reimbursing nonparticipating doctors, *Kartell v. Blue Shield of Massachusetts, Inc.*, 484 Mass. 409, 423, 425 N.E.2d 321 (1981).

The doctors here argue that Massachusetts state law cannot immunize Blue Shield's conduct because the relevant Massachusetts state law is preempted by federal pension law — the Employment Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001-1381 — and it is therefore without legal effect. We need not trace the labyrinthine path of this preemp-

tion argument, however, for we uphold the district court's ruling for a simpler reason. Since there is no relevant factual dispute, we have examined the legal merits of the doctors' substantive antitrust claim. We conclude that the facts to which they point do not make out a violation of the antitrust laws. No trier of fact, whether judge or jury, could properly find in their favor.

The doctors charge that Blue Shield simply refuses to deal with doctors who do not agree to participate in its program. The doctors strongly argued that this 'refusal to deal' helped Blue Shield implement its ban on balance billing. Were that ban unlawful, the 'refusal to deal' conceivably could have been found unlawful, too, as an unjustified means towards that unlawful end. If the ban is lawful, however, the 'refusal to deal' charge must rise, or fall, on its own. And, on its own, it runs squarely into basic antitrust law that a firm "generally has a right to deal, or refuse to deal, with whomever it likes, as long as it does so independently." *Monsanto Co. v. Spray-Rite*, 52 U.S.L.W. at 4343; *United States v. Colgate & Co.*, 250 U.S. 300, 307 (1919). There is nothing special here to take this case outside the general rule. There is neither evidence of a horizontal conspiracy nor any charge that Blue Shield agreed with one of its competitors not to deal with nonparticipating doctors. *Cf. Fashion Originators' Guild of America v. Federal Trade Commission*, 312 U.S. 457 (1941) (horizontal agreement to boycott certain customers held illegal). Any participation by Blue Cross in Blue Shield's decision is beside the point, for Blue Cross (a hospital cost insurer) does not compete with Blue Shield, nor does it maintain any relevant balance billing ban of its own. Thus, its (alleged) participation does not compromise in any relevant way the *independence* of Blue Shield's dealing decisions (anymore than, say, a hypothetical Blue Shield meeting with a business consultant). *Cf. Copperweld Corp. v. Independence Tube Corp.*, 52 U.S.L.W. 4821, 4825 (U.S. June 19, 1984). In

a nutshell, Blue Shield's independent determination of the terms on which it will deal, of the customers to whom it will sell, and of the suppliers from whom it will purchase is a manifestation of the competitive process, not an effort to suppress or to destroy that process. *Cf. Chicago Board of Trade v. United States*, 246 U.S. 231, 238 (1918) ("The true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition.").

Second, the doctors charge that Blue Shield engaged in "predatory" pricing behavior. And, they point to one instance, allegedly supported by the record, when Blue Shield charged a lower price for insurance than a competitor (a firm called GISC), and it later turned out that Blue Shield lost money on the policies. The district court held that the injury suffered as a result of any such predatory conduct, occurred only in the market for insurance; and the doctors did not have a sufficiently direct interest in competitive injuries in that market to give them 'standing' to complain of anticompetitive activity there.

On this appeal, the doctors challenge the court's ruling denying them standing to assert this Sherman Act § 2 claim. Like their first challenge, their argument would be far stronger had they prevailed on the 'balance billing' claim. Then, one might have accepted their claim that this single instance of "predatory pricing" was part and parcel of a bundle of anticompetitive activities designed to give Blue Shield significant market power in the medical insurance business. *See* Plaintiffs' First Amended Complaint, ¶ 18. And, anticompetitive activities that significantly lessen competition in that business can harm not only other insurance firms, 2 P. Areeda & D. Turner, *supra* ¶ 340a, but also customers of insurance firms, *id.* ¶ 337, and suppliers of insurance firms (such as doctors), *id.* ¶¶ 338-39. These harms, plaintiffs

assert, were great enough, and direct enough, to confer on suppliers (such as doctors) standing to complain of the anticompetitive conduct in a lawsuit and to seek equitable relief.

Once the 'balance billing' claim is eliminated, however, the doctors' argument lacks plausibility. They can no longer argue that insurance prices that reflect Blue Shield's 'balance billing' rule are automatically unlawful. The "predatory pricing" charge must stand on its own, and to succeed it requires a showing that the price was below "incremental cost" (or the equivalent). *See Barry Wright Corp. v. ITT Grinnell Corp., supra.* The only evidence to which the doctors can now point is the single, isolated instance in respect to GISC. GISC accounted for less than 1.0 percent of the health insurance market. Thus, even if the "predatory pricing" charge is true in respect to GISC, there is no evidence that the charged conduct could lead to any significant increase in Blue Shield's market power. Under these circumstances the possibility of injury to a supplier is simply too remote and indirect to allow a supplier to bring suit. Were the suit one for treble damages, the supplier's injury would be far too indirect to confer standing, *see Associated General Contractors of California v. California State Council of Carpenters,* 459 U.S. 519 (1983) (standing to assert treble-damages claim under § 4 of Clayton Act denied where plaintiff's injury was "indirect" and chain of causation tenuous). Although standing rules for an injunctive action under § 16 of the Clayton Act are more liberal, plaintiffs still must show that the charged conduct threatens them with harm. *Hawaii v. Standard Oil co.,* 405 U.S. 251, 260-62 (1972); 2 P. Areeda & D. Turner, *supra,* ¶¶ 328a, 335e. Plaintiffs cannot show this in respect to the GISC type of conduct. Thus, without the support of a 'balance billing' claim, the doctors cannot obtain a reversal of the district court's ruling that they lacked standing to complain of "predatory pricing."

Third, the doctors attack the district court's dismissal of their claims against Blue Cross. Massachusetts state law ex-

pressly authorizes Blue Cross and Blue Shield to contract with each other "for the joint administration of their business and for joint and co-operative writing and issuing of certificates." Mass. Gen. Laws ch. 176A, § 5; *see also id.*, ch. 176B, § 3. The district court therefore found that the "state action" doctrine and the McCarran-Ferguson antitrust exemption for the "business of insurance," 15 U.S.C. §§ 1011 *et seq.*, immunized Blue Cross's challenged conduct from antitrust scrutiny. Again, we need not accept the doctors' invitation to enter the legal thickets that surround these doctrines, for, with the demise of their 'balance billing' claim, the doctors are no longer able to make any plausible charge of a substantive antitrust violation. Once the ban on 'balance billing' is seen as permissible, the doctors' allegation against Blue Cross amounts to a claim that it conspired or agreed with Blue Shield to achieve a *lawful* objective, not an unlawful one. Blue Cross, concededly, is not a competitor of Blue Shield. There is no claim that the fact of agreement, in and of itself, inhibits any otherwise independently competitive action. *Cf. Fashion Originators' Guild of America v. Federal Trade Commission, supra.* Under these circumstances, the agreements violate no principle of antitrust law of which we are aware. Even were the agreements subject to substantive antitrust scrutiny, the doctors have failed to show us anything about them that would allow a finding of unlawfulness.

Fourth, and finally, the doctors assert the Blue Shield "has engaged in coercive attacks designed to intimidate and retaliate against physicians" — evidently those who oppose the ban on balance billing. As far as we can tell from the briefs, however, the activities that the doctors allege do not make out independent violations of the antitrust laws, once one accepts the fact that Blue Shield's balance billing rule is lawful. Even viewed in a light most generous to plaintiffs, the conduct they complain of at most might amount to minor

business torts, which lie beyond the purview of the antitrust laws, *see* 3 P. Areeda & D. Turner, *supra* ¶ 626d.

For these reasons, the district court's finding that the ban on balance billing is unlawful is reversed, and the district court's injunction is vacated. In all other respects the order of the district court is affirmed.

United States Court of Appeals
For the First Circuit

No. 84-1241

JAMES P. KARTELL, M.D., ET. AL.,
Plaintiffs, Appellees,

v.

BLUE SHIELD OF MASSACHUSETTS, INC.,
Defendant, Appellant.

No. 84-1290

JAMES P. KARTELL, M.D., ET. AL.,
Plaintiffs, Appellees,

v.

BLUE SHIELD OF MASSACHUSETTS, INC., ET AL.,
Defendants, Appellees.

MASSACHUSETTS MEDICAL SOCIETY, ET AL.,
Intervenors/Plaintiffs, Appellants.

No. 84-1303

JAMES P. KARTELL, M.D., ET. AL.,
Plaintiffs, Appellees,

v.

BLUE SHIELD OF MASSACHUSETTS, INC., ET AL.,
Defendants, Appellees.

COMMISSIONER OF INSURANCE,
Intervenor/Defendant, Appellant.

ERRATA SHEET

Please make the following correction in the opinion in the above case released on November 28, 1984:

At the bottom of the second page of the cover sheet insert the following footnote:

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* Of the U.S. Court of Appeals for the Federal Circuit, sitting by designation."

Appendix B

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

JAMES P. KARTELL, M.D., et al,
Plaintiffs

v. CIVIL ACTION
NO. 78-594-C

BLUE SHIELD OF MASSACHUSETTS, INC., et al,
Defendants.

OPINION

March 19, 1984

CAFFREY, Ch. J.

This is a private civil antitrust action which was originally filed against Blue Shield of Massachusetts, Inc. (Blue Shield) and Blue Cross of Massachusetts, Inc. (Blue Cross) in March of 1978 by four Massachusetts physicians. They request injunctive relief under § 16 of the Clayton Act, 15 U.S.C. § 26, for alleged violations of §§ 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1 and 2. The Massachusetts Commissioner of Insurance (the Commissioner) intervened as a party defendant in August 1979, and, in January 1982, by order of another judge of this Court, the Massachusetts Medical Society (the Society), Grant V. Rodkey, M.D. and Henry Brown, M.D. (collectively, "intervenor-plaintiffs") were permitted to intervene "as parties in the existing complaint."

The route from initial filing of the complaint six years ago to the 37-day non-jury trial of the case before this Court has been circuitous and tortuously slow, replete with procedural skirmishes and internecine disputes among plaintiffs who are represented by three different law firms. The case has been

assigned to five different judges of this Court, the first four of whom recused themselves. In one form or another, the matter has already been before the Supreme Judicial Court of Massachusetts on certified questions of Massachusetts law, and it has been before the Court of Appeals for the First Circuit on two occasions on appeals from rulings made by other members of this Court.

The original complaint was filed on March 10, 1978, and amended shortly thereafter. In the amended complaint, plaintiffs, now joined by intervenor-plaintiffs, allege that Blue Shield, in concert with Blue Cross, has restrained trade illegally in Massachusetts in both the market for physicians' services and the market for health insurance, in violation of §§ 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1 and 2. Specifically, plaintiffs allege[1] that Blue Shield engaged in unlawful price setting and restraint of trade in two ways: first, by requiring in most cases that physicians who have signed Participating Physicians' Agreements accept Blue Shield's reimbursement as payment in full; second, by refusing to reimburse doctors who have not signed Participating Physicians' Agreements with Blue Shield for services rendered by them to Blue Shield subscribers, except for services rendered in emergencies or rendered outside of Massachusetts.[2]

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[1] As is explained more fully below, the only remaining claim is that challenging the ban on balance billing.

[2] The plaintiffs also complain (1) that Blue Cross helps perpetuate Blue Shield's control over the compensation that can be earned by physicians by refusing generally to compensate physicians other than salaried health care providers on the staffs of institutions, primarily hospitals, that enter into agreements with Blue Cross; (2) that Blue Shield directs its subscribers not to use non-participating physicians, and its participating physicians not to refer patients to non-participating physicians; and (3) that Blue Cross directs its participating hospitals not to employ non-participating physicians.

On August 3, 1978, the Honorable Walter J. Skinner dismissed the amended complaint on the grounds that the challenged practices are compelled by state law, and are thus immune from antitrust attack under the "state action" doctrine enunciated by the Supreme Court in *Parker v. Brown*, 317 U.S. 341 (1943). The Court of Appeals for the First Circuit vacated that judgment in *Kartell v. Blue Shield of Massachusetts, Inc.*, 592 F.2d 1191 (1st Cir. 1979), ruling that the district court should have abstained from deciding the state law question — whether defendants' allegedly illegal practices were required by state statute. The Court of Appeals directed Judge Skinner to await the outcome of a case then pending before the Supreme Judicial Court of Massachusetts, *Nelson v. Blue Shield of Massachusetts, Inc.*, 577 Mass. 746 (1979), in which that issue was likely to be decided. The Court of Appeals added that, if the decision in the *Nelson* case did not provide sufficient guidance, Judge Skinner should consider certifying the relevant questions of state law to the Supreme Judicial Court for its consideration. *Id.* at 1195.

After determining that the Supreme Judicial Court's decision in *Nelson* did not speak to the statutory issues central to this case,[3] Judge Skinner certified two questions to the Supreme Judicial Court in January 1981. The questions were:

> 1. Is Blue Shield of Massachusetts, Inc. compelled by M.G.L. c. 176B, § 7 or any other Massachusetts statute or required by any clearly articulated and affirmatively expressed State policy (a) to limit fees of participating physicians as described in the annexed Stipulation and (b) to refuse to make payments for non-emergency services provided in Massachusetts by physicians who decline to accept the terms imposed by Blue Shield in their participation agreement, including such limitation of fees?

[3] In *Nelson*, the Supreme Judicial Court ultimately dismissed the complaint on the grounds that plaintiffs had failed to exhaust their administrative remedies.

> 2. Is Blue Cross of Massachusetts, Inc. permitted generally under the Massachusetts statutes to make payments to subscribers or physicians for medical services provided by physicians to Blue Cross-Blue Shield subscribers, as it does under its contract insuring employees of the Commonwealth?

The Supreme Judicial Court answered the certified questions on August 20, 1981, in *Kartell v. Blue Shield of Massachusetts, Inc.*, 1981 Mass. Adv. Sh. 1980 (1981). The Supreme Judicial Court's ruling enabled this Court to entertain cross-motions for summary judgment in April 1982.[4] In its memorandum and order of June 30, 1982, this Court held that the state action doctrine of *Parker v. Brown, supra*, immunizes most of the challenged conduct from antitrust attack. *Kartell v. Blue Shield of Massachusetts, Inc.*, 542 F. Supp. 782 (D. Mass. 1982). This Court ruled, however, that, to the extent that plaintiffs' complaint challenged Blue Shield's ban on balance billing, described *infra*, it is not barred by either the state action doctrine or the McCarran-Ferguson Act, 15 U.S.C. §§ 1011 *et seq.*, which exempts from the federal antitrust laws "the business of insurance . . . regulated by State law." *Id.* § 1012(b). This Court ruled, moreover, that it should not apply a "per se" price-fixing analysis to the ban on balance billing, but rather that it should apply a "rule of reason" analysis. Thus four years of legal sifting have yielded one central issue for this Court to resolve at trial: whether, as judged under the rule of reason, Blue Shield's ban on balance billing by participating physicians imposes an unreasonable restraint on competition.

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[4] The case was transferred to the undersigned on March 8, 1982, after Judge Skinner recused himself.

When I first met with counsel in this case on April 1, 1982, I informed them that I had subscribed to Blue Cross/Blue Shield for many years, and continue to subscribe to the program. I then asked counsel to make any objections to my hearing the case a matter of record at that time. None of the parties objected.

The case was tried non-jury to this Court for 37 trial days, beginning on April 19 and continuing until June 23, 1983. Plaintiffs and intervenor-plaintiffs called 24 witnesses for their case in chief and four rebuttal witnesses, resting their case on June 2, 1983. Defendants Blue Cross and Blue Shield called 12 witnesses between June 6 and June 22, and two witnesses in surrebuttal. Plaintiffs offered 176 exhibits which were accepted into evidence by the Court; defendants offered, and the Court accepted, 105 exhibits. These exhibits run to hundreds of pages containing thousands of numbers. This over-production has given the court the near-impossible task of deciding the credibility of two competing, undigestible piles of paper.[5] The Commissioner of Insurance called no witnesses and offered no exhibits.

This opinion will constitute the Court's findings of fact and conclusions of law pursuant to Fed.R.Civ.P. 52(a).

I. Parties

A. Plaintiffs

1. Plaintiffs James P. Kartell, M.D. and Herbert W. Horne, M.D. and the intervenor-plaintiff Henry Brown, M.D. are physicians who reside in and are licensed to practice medicine in Massachusetts. They do not participate in Blue Shield's medical service plan and are not parties to any written agreement with Blue Shield with respect to the performance of medical or surgical services.

2. Plaintiff Harry D. Wilson, M.D. and intervenor-plaintiff Grant V. Rodkey, M.D. are physicians who reside in and are licensed to practice medicine in Massachusetts. They participate in the medical service plan administered by Blue Shield and each has executed a Participating Physicians' Agreement.

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[5] Counsel for all parties in the case were unresponsive and unhelpful when the Court asked them for their suggestions as to how they expected the Court to resolve the credibility of these two competing mountains of mostly meaningless papers.

3. The intervenor-plaintiff Massachusetts Medical Society is a non-profit, special act corporation organized and existing under the laws of the Commonwealth of Massachusetts. Its 11,000-12,000 members include both participating and non-participating physicians.

B. Defendants

1. The defendant Blue Shield of Massachusetts, Inc., is a private, non-profit medical service corporation organized and existing under the laws of Massachusetts, with a principal place of business at 100 Summer Street, Boston, Massachusetts. Blue Shield is the only medical service corporation organized under Chapter 176B of the Massachusetts General Laws.

2. The defendant Blue Cross of Massachusetts, Inc., is a private, non-profit hospital service corporation organized and existing under the laws of Massachusetts, with a principal place of business also at 100 Summer Street, Boston, Massachusetts. Blue Cross is the only hospital service corporation organized under Chapter 176A of the Massachusetts General Laws.

3. The intervenor-defendant Commissioner of Insurance for the Commonwealth of Massachusetts is responsible under Chapter 176B of the Massachusetts General Laws to oversee and approve the structure and practices of Blue Shield.[6]

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[6] As this Court noted in its memorandum and order of June 30, 1982, 542 F. Supp. at 788, the Supreme Judicial Court of Massachusetts rejected defendants' claim that M.G.L. c. 176B invests in the Commissioner such absolute control over Blue Shield's operations that *any* existing Blue Shield scheme must necessarily be viewed as state policy and thus beyond the purview of federal antitrust law. *See Kartell v. Blue Shield of Mass., Inc.*, 1981 Mass. Adv. Sh. at 1992-94.

II. The Facts

Although this case has been pending for six years, the material facts have not changed since the original filing, nor, generally, are they disputed.[7]

Blue Shield is a medical service corporation, and Blue Cross is a hospital service corporation. They are organized under state law to provide "for the preservation of the public health by furnishing medical services at low cost to members of the public who become subscribers." 1941 Mass. Acts c. 306, preamble; Mass. G.L. c. 176B (Blue Shield); c. 176A (Blue Cross). As permitted by Mass. G.L. c. 176B, § 3, and c. 176A, § 5, Blue Shield has joined with Blue Cross for the joint administration of their affairs and for the issuance of joint subscriber contracts for both medical and hospital services.

Blue Shield directly compensates those doctors who participate in its medical services plan for services they render to about 90% of Blue Shield's subscribers. Participating physicians, in turn, agree to accept Blue Shield's payments (Blue Shield's "allowable") as payment in full for their services, even if the amount Blue Shield determines it will pay is less than the doctor's normal charge for his services. Participating doctors may not bill their patients for the balance. This feature is known as Blue Shield's ban on balance billing. Except in a few cases not of concern here, Blue Shield does not directly remunerate subscribers in any manner, and does not remunerate non-participating physicians for services rendered to subscribers, unless such services are rendered in an emergency, or are rendered outside the Commonwealth.[8]

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[7] For a more detailed history of Blue Shield and its reimbursement systems, see the opinion of the Supreme Judicial Court in *Kartell*, 1981 Mass. Adv. Sh. at 1985-89.

[8] As this Court held in its memorandum and order of June 30, 1982, 542 F. Supp. at 790-91, the refusal to remunerate non-participating physicians is, in and of itself, immune from antitrust challenge under the state action doctrine of *Parker v. Brown*, *supra*.

Blue Cross, on the other hand, is authorized by statute to provide coverage to its subscribers for hospital care and related procedures. Blue Cross does not remunerate physicians for services rendered to Blue Cross subscribers except those physicians who are salaried members of the staffs of institutions, primarily hospitals, which have entered into agreements with Blue Cross.[9]

Blue Shield provides some form of health insurance to at least 3.2 million Massachusetts residents, or 56% of the population of the Commonwealth. Approximately 99% of the state's doctors in fee-for-service practice participate in Blue Shield's medical service plan.

Blue Shield was incorporated under Mass. G.L. c. 176B in May 1942. On September 18, 1942, the Commissioner of Insurance, pursuant to his powers under c. 176B, gave his approval to the first subscription contract, and to the first schedules of subscriber rates and physician fees. He also approved the initial Participating Physicians' Agreement, which remains unchanged to this day. The agreement provides in relevant part that:

> [t]he Participating Physician agrees to accept as full compensation for all . . . services such payments as are received from the Corporation . . . except in the case of those persons who are entitled only to Limited Indemnification, in which case the physician may make his customary charge to the patient for his services, crediting against such charge the amount set forth for such services in the fee schedule in effect at the time the services are rendered.

The original subscription certificate created two classes of subscribers. "Unlimited" subscribers, whose personal or family income was below a certain figure, received unlimited

[9] Blue Cross also reimburses those physicians who treat Massachusetts state employees who are subscribers under a Blue Cross plan available only to employees of the Commonwealth.

coverage from doctors in return for their premium payments. "Limited" subscribers, whose income was above a certain figure, could be balance billed by participating physicians for charges in excess of Blue Shield's allowable. This method of classification was known as "Plan A."

In 1951, Blue Shield implemented a second plan, known as "Plan B," to supplement Plan A. The new plan divided the class of "unlimited" subscribers into two subclasses based on their income levels. Blue Shield charged the higher income subscribers higher premiums and Blue Shield paid participating physicians a higher allowable for services rendered to those subscribers. Blue Shield continued to allow participating physicians to balance bill limited subscribers.

In 1956, Blue Cross and Blue Shield initiated the Master Medical Certificate, which provided comprehensive coverage of hospital and medical costs under a single plan. They continued to determine the extent of an individual subscriber's coverage according to his or her income.

In Blue Shield's first years of operation, nearly 90% of its subscribers were "unlimited" subscribers, and thus were not subject to balance billing by participating physicians. However, this percentage gradually declined during the late 1950's and 1960's, in part due to the effect of inflation on the real value of Blue Shield's fixed income limits. By 1967, fewer than 50% of Blue Shield's subscribers were still below the prescribed income levels, leaving more than half the subscribers subject to balance billing. I find that Blue Shield came under increased pressure from its subscribers to devise a new coverage that would provide full service benefits to subscribers regardless of their income levels.

At the same time, a growing number of doctors were becoming dissatisfied with the reimbursement system. I find that a 1966 survey showed that "90% of the doctors in the state of Massachusetts accept the Blue Shield fee whether or not their patient is over income." However, Blue Shield pay-

ments for most services on the fee schedules had not been raised since 1952 even though doctors' charges had increased significantly in the intervening 15 years. By 1967-68, Blue Shield payments were on the average 30% below the fees usually charged by doctors.

In late 1967 or early 1968, in an attempt to respond to the rising tide of criticism from both subscribers and doctors, Blue Shield submitted to the Commissioner of Insurance a proposed "Amended Schedule of Benefits — Blue Shield Portion of the Blue Cross — Blue Shield Master Medical Certificate," which introduced the "usual and customary charge" method of compensation. The 1968 Amended Schedule of Benefits was approved by the Commissioner of Insurance effective February 1, 1968.

Under the usual and customary charge method of compensation adopted in 1968, the basic mechanics of which are still in use today, Blue Shield did not pay a predetermined, fixed amount for a service as it had under the earlier, fixed-fee system. Rather, the participating physician received from Blue Shield a payment of 95% of the lowest of (a) the doctor's submitted charge, (b) the doctor's "usual charge" (Level I), or (c) the "customary charge" for the service (Level II). Blue Shield deducts five percent to cover administrative costs. A doctor's "usual charge" for a given service is the median of the individual doctor's charges reported to Blue Shield during the applicable charge reporting period. The "customary charge" for a given service is the 90th percentile of the usual charges reported by doctors within the same specialty and geographic area during the applicable charge reporting period. Under the usual and customary charge method, participating physicians were not permitted to balance bill their patients.

As originally implemented, the new system contained no limitation on year-to-year increases in the usual and customary charge levels. While participating physicians were re-

quired under this method of compensation to accept Blue Shield's fees as payment in full for covered services regardless of a subscriber's income,[10] the advantage of this system to participating physicians was the "promise of higher fees immediately for many services and relatively automatic future adjustments for inflation." *Kartell*, 1981 Mass. Adv. Sh. at 1988.

From 1968 until 1975, Blue Shield updated usual and customary charges as it deemed appropriate, without objection from the Commissioner. However, in the eighteen months preceding April 30, 1976, Blue Shield's reserves plunged nearly $25 million. In an effort to contain costs and restore fiscal health to the corporation by rebuilding its reserves, Blue Shield indefinitely deferred the 1976 profile update. By March 1, 1977, the financial condition of the corporation had improved. Blue Shield then filed an amended schedule of benefits designed, according to the testimony of its President, John Larkin Thompson, to reinsure fiscal stability and to provide cost containment. The 1977 Amended Schedule of Benefits was approved by the Commissioner of Insurance and incorporated by reference in the Participating Physicians' Agreement. It provided that the percentage increase in usual and customary payments may be "limited to such amount as Blue Shield may determine" without regard to any specific formula, and that the percentage increase in "customary charges" for the applicable period may not exceed the percentage increase in the Consumer Price Index for Urban Wage Earners and Clerical Workers, Boston, All Items, less the medical care component of the Index.

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[10] When this method was first proposed in 1968, it was to be implemented only for group accounts under the Master Medical Certificate and for Blue Shield's coverage of the Federal Employee Program. At present, however, it applies to all accounts except the few remaining Plan B subscribers. Approximately 90% of Blue Shield members now have coverage which includes the ban on balance billing.

Prior to July 1, 1977, the date on which the 1977 Amended Schedule of Benefits was approved, "customary" payment levels for each procedure were, in fact, calculated at the 90th percentile of all submitted charges, I find that, in each year since 1977, Blue Shield has limited the allowable percentage increase in "customary" payment levels, in most cases, to an increase less than the rise in the Consumer Price Index. As a result, the "customary" payment levels for a given procedure are now most often lower than the 90th percentile of the submitted "usual charges."

The 1977 Amended Schedule gave Blue Shield the sole authority to determine charge reporting periods used to compute updates of usual and customary charges. Blue Shield has established as its charge reporting period the calendar year preceding each annual July update. For example, the July 1, 1983, update which remains in effect until June 30, 1984, is based on charges submitted during calendar year 1982. As a result, Blue Shield bases its usual and customary payment levels on actual charges that are between 6 and 30 months old.

In each year since 1977, total payments by Blue Shield to participating physicians under the Amended Schedule have been substantially less than the total charges submitted by the doctors. For services rendered by participating physicians to Blue Shield subscribers whose coverage includes the ban on balance billing, the aggregate difference between charges submitted by doctors and Blue Shield payments was $69 million in 1979, $73 million in 1980, $81 million in 1981, $94 million in 1982, and was projected to be $103 million in 1983. The difference between submitted charges and payments, as a percentage of total doctors' charges in Massachusetts, grew from 18.4% in 1976 to 30.7% in 1981, and today remains close to the 30% figure.

I find that Blue Shield has evolved into the single most powerful actor in the various markets for health services in

Massachusetts and that at the present time 99% of the practicing doctors in Massachusetts are Blue Shield participating physicians. I find, in addition, that defendant Blue Shield's 3.2 million subscribers constitute approximately 56% of the population of Commonwealth. Some 2.5 million of those subscribers, or approximately 45% of the total population, have Blue Cross/Blue Shield coverage which is subject to the ban on balance billing.

Moreover, I find that Blue Shield has, by any measure, the dominant market share in the market for prepaid health care in the state. At trial there was voluminous and conflicting testimony as to how best to measure market share in the market for prepaid health care. The Court accepted evidence as to the market share measured by, for example, percentage of population, percentage of privately insured population, percentage of premiums paid, percentage of total health care services expenditures, and percentage of total prepaid health care expenditures. The evidence shows that, as of 1981, Blue Shield and Blue Cross provided coverage for approximately 74% of the privately-insured population in Massachusetts; only 23% of the population had coverage with commercial insurers, and less than 4% of the population was then covered by independent Health Maintenance Organizations (H.M.O.'s).

III. Analysis

The issue before the Court in this case is whether Blue Shield's ban on balance billing constitutes a restraint of trade, monopolization or an attempt to monopolize in violation of §§ 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1 and 2. Section 1 of the Sherman Act of 1890 provides, in pertinent part, that

> [e]very contract, combination ... or conspiracy, in restraint of trade or commerce among the several States, ... is declared to be illegal....

15 U.S.C. § 1 (1973). Section 2 of the Act provides, in relevant part, that

> [e]very person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, . . . shall be deemed guilty of a felony. . . .

15 U.S.C. § 2 (Supp. 1983).

The allegedly anticompetitive effect of conduct challenged under the antitrust laws can be analyzed and evaluated properly only in the context of a well-defined market place. An antitrust plaintiff can make out a prima facie case only upon "proof of a well-defined relevant market upon which the challenged anticompetitive actions . . . have had a substantial impact." *Cornwell Quality Tools Co. v. C.T.S. Co., Inc.*, 446 F.2d 825, 829 (9th Cir. 1971), *cert. denied*, 404 U.S. 1049 (1972). Accordingly, this Court must determine the product market and the geographic market in which the restraint is alleged to have occurred.

In this case, plaintiffs allege that defendants' conduct has had an illegal impact on two distinct geographic and product markets: (1) the market for physicians' services in Massachusetts, and (2) the market for prepaid health care in Massachusetts. I find that the parties are in essential agreement as to the definition of the markets at issue.

I rule that the market for physicians' services consists of doctors licensed in Massachusetts who treat patients on a fee-for-service basis. Doctors in that market provide various services, including surgery, anesthesiology, obstetrics, gynecology, neurology, radiology, internal medicine, and their numerous sub-specialties. Likewise, while some doctors attract patients from outside the state, or from across the state, and others compete in more localized areas, the parties have stipulated, and I find, that the relevant geographic market is the entire state of Massachusetts.

I rule that the market for prepaid health care includes those organizations which provide some form of health care coverage that can be substituted for, and therefore competes with, coverage provided by Blue Cross and Blue Shield of Massachusetts.[11] I find that the relevant product market includes Blue Cross and Blue Shield, commercial insurance companies such as Aetna, Prudential and Travelers, health maintenance organizations (H.M.O.'s), administrative service only companies (ASO's), and employers who self-insure large groups of their own employees. I find, in addition, that it does not include purely governmental programs, like Medicare. I accept the opinion of Dr. Frech, plaintiffs' expert, that the government programs should be excluded from this market because no private company, including Blue Cross/Blue Shield, can effectively offer the same product as, or compete with, the government programs. Moreover, I find that the relevant geographic market for use in evaluating the effect of Blue Shield's practices is the entire state of Massachusetts.

A. Standing

Throughout the course of this litigation defendants have contended consistently that plaintiffs, individually and collectively, lack standing to maintain this antitrust action in each of the relevant markets. Prior to trial, the parties had not developed the record sufficiently to enable the Court to rule whether plaintiffs have antitrust standing. On the basis of the evidence produced at trial, this Court can and will now make that ruling.

Plaintiffs and intervenor-plaintiffs seek injunctive relief under § 16 of the Clayton Act, 15 U.S.C. § 26. Section 16 defines the class of persons who may sue for relief under that section:

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[11] Though plaintiffs steadfastly and pointedly referred throughout the trial to this second market as the "market for private health insurance," their market definition is, in fact, substantially similar to that of defendants, whose nomenclature I now adopt.

> Any person, firm, corporation, or association shall be entitled to sue for and have injunctive relief, in any court of the United States having jurisdiction over the parties, against threatened loss or damage by a violation of the antitrust laws, . . . when and under the same conditions and principles as injunctive relief against threatened conduct that will cause loss or damage is granted by courts of equity. . . .

15 U.S.C. § 26 (1973). Read literally, the statute appears to make actionable every harm that can be attributed directly or indirectly to the consequences of an antitrust violation. Yet common sense and *stare decisis* require this Court to take a more restrictive view of standing under § 16.

> [T]he focus of the doctrine of "antitrust standing" is somewhat different from that of standing as a constitutional doctrine. Harm to the antitrust plaintiff is sufficient to satisfy the constitutional standing requirement of injury in fact, but the court must make a further determination whether the plaintiff is a proper party to bring a private antitrust action.

Associated General Contractors of California, Inc. v. California State Council of Carpenters, ____ U.S. ____, 51 U.S.L.W. 4139, 4144 n.31 (U.S. Feb. 22, 1983).

Under § 16, plaintiffs must show "(1) a threatened loss or injury cognizable in equity (2) proximately resulting from the alleged antitrust violation." *City of Rohnert Park v. Harris,* 601 F.2d 1040, 1044 (9th Cir. 1979), *cert. denied,* 455 U.S. 961 (1980). They must also show that the "illegal act is linked to a plaintiff engaged in activities intended to be protected by the antitrust laws." *Reibert v. Atlantic Richfield Co.,* 471 F.2d 727, 731 (10th Cir. 1973), *cert. denied,* 411 U.S. 938 (1973).

Defendants challenge plaintiffs' standing to maintain an action for restraint of trade in the market for prepaid health care, relying primarily on the recent Supreme Court decision

in *Associated General Contractors of California, Inc. v. California State Council of Carpenters*, ___ U.S. ___, 51 U.S.L.W. 4139 (U.S. Feb. 22, 1983). In that case, a carpenters' union alleged that the defendant State Council of Carpenters had restrained trade by coercing general contractors, landowners, and others engaged in construction work to contract with non-union carpenters and firms, thereby reducing the ability of certain unionized firms to compete for those contracts.[12] The Supreme Court rejected the union's claim to standing for a number of reasons which apply in this case.

The Court observed, first, that the central interest of the antitrust laws lies in "protecting the economic freedom of *participants* in the relevant market." *Id.* at 4144 (emphasis added). The Court denied standing to the union in part because if "was neither a consumer nor a competitor in the market in which trade was restrained." *Id.* at 4145. That factor weighs heavily in this case against plaintiffs' claim to standing in the market for prepaid health care because plaintiffs are not consumers or competitors in that market. On the contrary, plaintiffs are contractually involved with defendants only in an altogether different market, the market for physicians' services.

Another factor militates against a finding that plaintiffs have standing in the market for prepaid health care. In *Associated General Contractors* the Supreme Court observed that

> [t]he existence of an identifiable class of persons whose self-interest would normally motivate them to vindicate the public interest in antitrust enforcement diminishes the justification for allowing a more remote party such as the Union to perform the office of a private attorney general. Denying the Union a remedy on the basis of its allegations in this case is not likely to leave a significant antitrust violation undetected or unremedied.

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[12] *Associated General Contractors* was an action for damages brought under § 4 of the Clayton Act, 15 U.S.C. § 15. However, the majority of the policy considerations enumerted by the Court are relevant to the present analysis of standing for injunctive relief.

Id. at 4145-46. That reasoning applies squarely in this case. I find that the private insurance companies which compete in Massachusetts in the health care market and whose representatives appeared as witnesses at the trial constitute an identifiable class of persons whose self-interest would obviously motivate them to sue if the alleged violation were to exist in the market for prepaid health care. Moreover, a ruling that denies plaintiffs standing to maintain an action in the market for prepaid health care does not in any way leave a "significant antitrust violation undetected or unremedied." If this Court finds that defendants' conduct in the market for physicians' services violates antitrust laws, plaintiffs will obtain the same relief that they seek for alleged violations in the market for prepaid health care.

Plaintiffs also rely on the 1982 decision of the Supreme Court in *Blue Shield of Virginia v. McCready,* 457 U.S. 465 (1982), to establish their standing to complain of a restraint in the market for prepaid health care. Plaintiffs' reliance on *McCready* is misplaced because of the substantial factual differences between *McCready* and this case. McCready alleged that she was a consumer of psychotherapeutic services and that she had been injured by defendant Blue Shield's conspiracy to restrain competition in the market for such services.[13] Plaintiffs in this case are not consumers in the market for prepaid health care, nor do they sell services in that market. Moreover, the Court in *McCready* noted specifically that while McCready had standing to maintain an action as a consumer market for *psychotherapeutic services,* she did not "allege a restraint in the market for *group health plans.*" *Id.* at 480 (emphasis added).

[13] McCready, a Blue Shield subscriber, alleged that Blue Shield and the Neuropsychiatric Society of Virginia, Inc. had unlawfully conspired to restrain competition in the market for psychotherapeutic services by providing insurance coverage only for consumers who patronized psychiatrists, not psychologists. McCready had obtained services from a psychologist and had been denied reimbursement.

Since the plaintiff physicians in this case participate only as vendors in the *market for physicians' services,* they can only sustain a legally cognizable injury in that market, and can only challenge the ban on balance billing as a restraint in that market. Even if defendants have used illgotten power in the market for prepaid health care as the primary weapon to inflict injury upon plaintiffs as functioning actors in the *market for physicians' services,* that fact does not bestow upon plaintiffs standing to allege a restraint in the market for prepaid health care.

Defendants also argue that plaintiffs lack standing to allege an antitrust violation in the market for physicians' services. The Sherman Act protects the economic freedom of *participants* in the markets where they compete. *See United States v. Topco Associates, Inc.,* 405 U.S. 596 (1972). The doctors sell their services in the market for physicians' services. As vendors in the market for physician' services, they have standing to challenge a restraint of trade in that market. Moreover, the participating physicians also allege that Blue Shield's compensation scheme distorts the market place and has wide-ranging detrimental effects on doctors' freedom and ability to innovate and to engage in non-price competition. Those injuries are certainly "of a type that Congress sought to redress in providing a private remedy for violations of the antitrust laws." *McCready,* 457 U.S. at 483.

Those doctors who have chosen not to sign Participating Physicians' Agreements with Blue Shield have also alleged a legally cognizable antitrust injury. They claim that their refusal to sign the participation agreement effectively precludes them from attracting a large percentage of the state's population as patients. Such a curtailment of competition in the market and refusal to deal would constitute a cognizable antitrust injury. Non-participating doctors are not precluded from bringing suit to restrain the ban on balance billing simply because they refuse to join in the alleged antitrust consipiracy.

B. Plaintiffs' Section 1 Claims

Section 1 of the Sherman Act literally prohibits every contract, combination or conspiracy in restraint of trade. But over the years, courts have read § 1 to prohibit not *every* contract in restraint of trade, but only *unreasonable* restraints of trade. *Standard Oil Co. of New Jersey v. United States,* 221 U.S. 1 (1911); *Chicago Bd. of Trade v. United States,* 246 U.S. 231, 238 (1918). This Court has already ruled that the provider agreements between Blue Shield and participating doctors do not constitute *per se* price-fixing but should be judged under the rule of reason.[14] *Kartell v. Blue Shield of Massachusetts,* 542 F.Supp. at 794. Other courts have almost uniformly applied the rule of reason analysis to similar agreements.[15] *See, e.g., Sausalito Pharmacy, Inc. v. Blue Shield of California,* 544 F.Supp. 230 (N.D. Cal. 1981), *aff'd per curiam,* 677 F.2d 47 (9th Cir. 1982); *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut,*

[14] Plaintiffs also allege that Blue Shield and Blue Cross have engaged in a horizontal restraint of trade by their joint medical care certificate and their other marketing agreements and joint administration. M.G.L. c. 176A, § 5 and c. 176B, § 3 expressly authorize Blue Cross and Blue Shield to contract with each other "for the joint administration of their business and for joint and co-operative writing and issuing of certificates." Because any such agreement between Blue Cross and Blue Shield is likely exempt from antitrust scrutiny by virtue of the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq., see, e.g., Quality Auto Body, Inc. v. Allstate Insurance Co.,* 660 F. 2d 1195, 2000-01 (7th Cir. 1981), and by virtue of the state action exemption, *see Parker v. Brown,* 317 U.S. 341 (1943), I analyze only the vertical arrangements between Blue Shield and the individual physicians.

[15] In *Arizona v. Maricopa County Medical Society,* 457 U.S. 332, (1982), the Supreme Court found a similar, but distinguishable, insurance scheme to be a *per se* violation and went on to note that "this case [does not] present the question whether an insurer may, consistent with the Sherman Act, fix the fee schedule and enter into bilateral contracts with individual doctors. That question was not reached in *Group Life & Health Insurance Co. v. Royal Drug Co.,* 440 U.S. 205 (1979)." *Id.* at 353 n.26.

Inc., 675 F.2d 502 (2d Cir. 1982); *Glen Eden Hospital, Inc. v. Blue Cross & Blue Shield of Michigan*, 555 F.Supp. 337 (E.D. Mich. 1983); *Blue Cross & Blue Shield of Michigan v. Michigan Association of Psychotherapy Clinics*, 1980-2 Trade Cas. (CCH) ¶ 63,351 (E.D. Mich. 1980).

Justice Brandeis provided the classic statement of the rule of reason in *Chicago Bd. of Trade v. United States*, 246 U.S. 231, 238 (1918):

> The true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition. To determine that question the court must ordinarily consider the facts peculiar to the business to which the restraint is applied; its condition before and after the restraint was imposed; the nature of the restraint and its effect, actual or probable. The history of the restraint, the evil believed to exist, the reason for adopting the particular remedy, the purpose or end sought to be attained, are all relevant facts. This is not because a good intention will save an otherwise objectionable regulation or the reverse; but because knowledge of intent may help the court to interpret facts and to predict consequences.

The rule of reason requires the fact finder to decide whether under all the circumstances of the case the restrictive practice imposes an *unreasonable* restraint on competition. A restraint is unreasonable if it has the net effect of substantially impeding competition. *See National Society of Professional Engineers v. United States*, 435 U.S. 679, 687-92(1978).

Defendants contend that the special characteristics of the physicians' services market make it inappropriate for the Court to apply traditional antitrust analysis to the ban on balance billing. The fact that the market for physicians' services bears little likeness to the econometric models of "pure competition" does not exempt it from antitrust scrutiny. As the Supreme Court reiterated in *Professional Engineers:*

> The early cases . . . foreclose the argument that because of the special characteristics of a particular industry, monopolistic arrangements will better promote trade and commerce than competition. [Citation omitted]. That kind of argument is properly addressed to Congress and may justify an exemption from the statute for specific industries, but it is not permitted by the Rule of Reason.

Id. at 689-90. Congress has not chosen to exempt the health care industry from the purview of antitrust litigation, and the Supreme Court has been reluctant to create any such exemption. Congress has recently made the "*strengthening of competitive forces* in the health services industry" a matter of national priority and has directed that special consideration be given throughout the planning process to the importance of maintaining and improving competition in the health industry. National Health Planning and Resources Development Act of 1974, 42 U.S.C. § 300k-2(a)(17) (1982) (emphasis added). Moreover, in *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982), the Supreme Court specifically refused to create such a judicial exemption for the physicians' services market. *See id.* at 354-55.

Defendants argue that the ban on balance billing should not be subject to traditional rule of reason analysis for another reason. They claim that the ban on balance billing makes it possible for Blue Cross and Blue Shield to satisfy the strong and otherwise unsated consumer demand for low-cost, comprehensive coverage. It enables Blue Cross and Blue Shield, they argue, to hold down increases in medical costs and, in that way, to minimize increases in subscriber premiums. I rule that, in essence, this is the same argument the Supreme Court rejected summarily in *Maricopa*. The Court of Appeals in that case had upheld the challenged restraint because it served as an effective cost-containment mechanism saving patients and insurers millions of dollars, and because it had facilitated the successful marketing of an attractive insurance plan. *See Arizona v. Maricopa County Medical Socie-*

ty, 643 F.2d 553 (9th Cir. 1980). The Supreme Court rejected that reasoning and found a § 1 violation, calling the test the Court of Appeals had applied "a legal standard based on the reasonableness of the fixed prices, an inquiry [the Supreme Court has] so often condemned." 457 U.S. at 350. Even though a challenged restraint may benefit consumers in the short term, anticompetitive restraints inevitably lessen consumer welfare in the long term. As this Court recently observed in another antitrust case:

> In our economy, ... prices are set by the impersonal forces of competition, and not by consumer preference. Furthermore the law protects the impersonal forces of competition, rather than consumer preference, on the basis that economic forces will ultimately enhance consumer welfare.

M&H Tire Co., Inc. v. Hoosier Racing Tire Corp., 560 F. Supp. 591, 606 (D. Mass. 1983).

I turn now to the very heart of the controversy before this Court: whether the ban on balance billing has the net effect of *promoting or suppressing competition* in the market for physicians' services in Massachusetts. It is defendants' contention not only that plaintiffs have failed to demonstrate any significant harm to competition arising from the ban, but also that the ban has, in fact, numerous procompetitive effects.

Defendants argue that the ban on balance billing *promotes* competition in the market for physicians' services in three ways. First, they contend that, because Blue Cross and Blue Shield provide the inexpensive comprehensive health care coverage which the public demands, they act as entrepreneurial competitors, enhancing, not undermining, the competitive process. But I rule that even if their alleged entrepreneurial activity enhances competition, it does so only in the market for prepaid health care. It does not enhance competition in the market for physicians' services.

Second, defendants argue that the ban on balance billing promotes competition because it protects subscribers from

unrestrained pricing by physicians. Lower prices, in and of themselves, do not necessarily represent enhanced competition, because they can just as easily result from an illegal restraint. Furthermore, as noted above, the fact that "reasonable" fees result from the restraint does not justify an otherwise unlawful restraint of trade. I rule, therefore, that that claim is without legal merit.

Third, defendants argued through the testimony of their expert witness that the ban on balance billing promotes competition becasue it has produced a pricing structure similar to the pricing structure one would expect to find in a market where price competition is widespread. But defendants' expert witness, Dr. Dyckman, conceded that, although he believed that prices now charged by physicians are higher than they should be, he had no idea what a reasonable competitive price would be for any of the thousands of procedures listed in defendants' Basic Benefit Schedule, all of which are subject to the ban. Moreover, I observe once again that, even if reasonable competitive prices could be determined by an individual, by Blue Shield, or by this Court, The reasonableness of a pricing structure engendered by an otherwise unlawful restraint does not justify the restraint.

Finally, it would be inequitable to allow defendants to justify the ban on balance billing as necessary to counter uncompetitively high prices in the market place when defendants themselves caused much of the price inflation in that market through their usual and customary charge method. I find that the usual and customary charge method as originally enacted discouraged participating physicians from reducing prices, or from modifying their fees to reflect actual time and effort expended on a particular patient. If a doctor were to lower prices to some patients, he would lower his "usual charge' profile, thereby reducing the amount Blue Shield would reimburse him in the future. The methodology gave doctors an artificial incentive to develop unrealistically high

charges, in recognition of the fact that their next Level I "usual" profile updates would reflect their higher fees. Defendants acknowledge that Blue Shield adopted the Amended Schedule of Benefits in 1977, with its cap on usual and customary profile updates, in order to break the inflationary spiral of medical costs caused in part by the usual and customary charge method.

To allow defendants unilaterally to impose a "reasonable" price structure in order to counteract high prices which they themselves fostered would surpass the bounds of reason and be abominably bad antitrust law. I find, therefore, that even if it is assumed that the ban on balance billing has some beneficial effects in other areas, it does not *promote competition.*

Defendants also contend that, even if the ban on balance billing constitutes a restraint of trade, it is not an *unlawful* restraint. They rely on the decisions in two recent cases involving similar Blue Cross and Blue Shield provider agreements, *Sausalito Pharmacy, Inc. v. Blue Shield of California,* 544 F.Supp. 230 (N.D. Cal. 1981), *aff'd per curiam,* 677 F.2d 47 (9th Cir. 1982), and *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut, Inc.,* 675 F.2d 502 (2d Cir. 1982). The Courts in *Sausalito* and *Medical Arts* ruled that contracts between Blue Shield and participating pharmacies do not restrain trade impermissibly unless there is some effect on price formation, or on competitive conduct or conditions, that is independent of what the terms of the contract require. The allegedly illegal restraint in those cases — agreements between sellers and buyers setting a price for fungible goods — was the same "price-fixing" that accompanies every contact. *See Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.,* 441 U.S. 1, 5 (1979). It is defendant's contention that the allegedly anticompetitive effects of the ban on balance billing are directly analogous to the alleged effects which were held not to rise to the level of a Sher-

man Act violation in both *Sausalito* and *Medical Arts*. However, those cases are legally and factually distinguishable from the case at bar.[16]

In both *Sausalito* and *Medical Arts*, plaintiffs challenged the provider agreements solely on the ground that the agreements constituted a price-fixing conspiracy, and were thus *per se* violations of § 1. The courts did not scrutinize the agreements under the rule of reason standard. The plaintiffs in those cases had not alleged, nor had they presented evidence to show, that the agreements had an extra-contractual effect on prices or competition. Because the provider agreements in those cases did not constitute *per se* price-fixing violations, the courts granted summary judgement for the defendants and did not consider whether the agreements violated the rule of reason. Plaintiffs in this case have not only alleged anticompetitive effects that reach beyond the price terms of the provider agreements, but they have presented voluminous evidence in support of their claims.

Moreover, the plaintiff pharmacies in *Sausalito* and *Medical Arts* complained, in effect, simply about the unfavorable terms of contracts into which they had entered

[16] In *Sausalito* and *Medical Arts*, plaintiff pharmacies unsuccessfully challenged provider agreements between themselves and Blue Cross. The agreements between Blue Cross and participating pharmacies established the maximum prices which pharmacies could recover for prescription drugs supplied to Blue Cross subscribers. Under the reimbursement plan examined by the court in *Medical Arts*, which is substantially similar to the provider agreement at issue in Sausalito, Blue Cross subscribers who patronized "participating" pharmacies (*i.e.*, those who had entered into agreements with Blue Cross) were required at most to pay the pharmacy a small "deductible" amount, and the pharmacy was reimbursed by Blue Cross at the rate established in the agreement. Subscribers who patronized non-participating pharmacies paid the pharmacies the over-the-counter prices for prescriptions, and were reimbursed by Blue Cross at the rate established in the subscriber agreement with Blue Cross.

voluntarily. In *Medical Arts*, the district court found specifically that, while the terms of the provider contract were determined unilaterally by Blue Cross, the individual pharmacies did have a meaningful economic choice as to whether or not to sign the contracts.[17] In fact, only 9% of the Connecticut population was eligible for Blue Cross prescription drug benefits, and sales to Blue Cross members amounted to only 9% of the statewide sales volume. 518 F. Supp. 1100, 1103 (D. Conn. 1981). Nothing in the opinion of either the district court or the court of appeals implies that the case would have lent itself to disposition on summary judgment if plaintiffs had been able to show that they were the victims of economic coercion rather than of their own business (mis)judgment. *See Medical Arts*, 675 F.2d at 507; 518 F. Supp. at 1108 n.9.

The facts in this case are substantially different. The testimony at trial establishes, and I find, that under the current Blue Shield payment system, which incorporates the ban on balance billing, Massachusetts physicians have absolutely no meaningful economic choice except to agree to the pricing terms unilaterally established by defendants.[18] Physician participation is not voluntary in any sense of the word, but is, rather, a matter of economic necessity. I find that the fact that over 99% of the state's practicing doctors have signed the participation agreement, and continue to acquiesce in the increasingly restrictive and unfavorable pricing system, proves Blue Shield's economic power, and also proves that there is very heavy economic pressure on doctors to participate.

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[17] The district court's opinion appears at 518 F. Supp. 1100 (D. Conn. 1981).

[18] Plaintiffs acknowledge that defendants, and any other health insurers, are entitled to limit what *they* pay to physicians for medical services rendered to subscribers. Plaintiffs only contest an insurer's right to limit the *total amount* a physician can receive for medical services rendered.

I find that because nearly 60% of all Massachusetts residents subscribe to Blue Cross/Blue Shield, doctors in Massachusetts *must* accept defendants' pricing terms in order to maintain a viable practice in the state. A physician who refuses to participate in the Blue Cross/Blue Shield plan is effectively foreclosed from treating almost two-thirds of the state's residents as patients. By contrast, the Blue Cross plan in *Medical Arts* provided that subscribers would be partially remunerated even for prescriptions filled by non-participating pharmacists. In that way, non-participating pharmacies were not foreclosed completely from dealing with Blue Cross subscribers. Consequently, they had an economically viable, though less lucrative, alternative to participation.

Moreover, while there was conflicting testimony in this case as to the percentage of physician income contingent upon Blue Shield participation, it is clear that a doctor in Massachusetts, when deciding whether or not to sign the participation agreement, must consider factors other than simply the 13-14% of physician practice revenue paid by Blue Shield which is directly derived from services subject to the ban. When Blue Shield payments for services *not* covered by the ban are added in, Blue Shield payments constitute approximately 20% of total physician income. Moreover, I find that participating physicians derive a substantial percentage of their income from out-of-pocket payments by Blue Shield subscribers for non-covered services and from non-subscribers referred to them by other participating physicians. These sources of income are inevitably foreclosed if the doctor decides *not* to sign the participation contract.

In short, I find that Blue Shield "delivers" a much larger percentage of total physician income than the amount of its own payments and I find that its enormous leverage over physicians derives from the amount of physician income it controls.

Drs. Brown, Wilson, Yerkes, Sloss, Rodkey and Kartell testified that it is economically impossible for a non-participating physician to maintain a viable practice in Massachusetts and I so find. In light of that testimony and the particular circumstances of this case, it would be contrary to fact and legally untenable for this Court to find that plaintiffs have *voluntarily* signed the participation agreements, and to rule that they are, therefore, precluded from challenging the allegedly anticompetitive restraint which the contract terms produce.

For the reasons set forth above, I decline to follow the ruling of the courts in *Medical Arts* and *Sausalito.* Yet, the burden of proof set out in those cases remains relevant to this case: plaintiffs must establish that the ban on balance billing has an "effect on price formation, or other type of restraint of trade, independent of what the contract terms . . . require." *Sausalito,* 544 F. Supp. at 235, *quoting Blue Cross & Blue Shield of Michigan v. Michigan Association of Psychotherapy Clinics,* 1980-2 Trade Cas. (CCH) ¶63,351 at 75,795 (E.D. Mich. 1980).

In their effort to establish that Blue Shield's current reimbursement system has had, and continues to have, a substantial anticompetitive effect on the market for physicians' services, plaintiffs rely heavily on the 1982 Supreme Court decision in *Arizona v. Maricopa County Medical Society, supra.*[19] This Court is well aware that there are major differences between the Blue Shield system incorporating the ban on balance billing that is under consideration in this case and the insurance plan which the Supreme Court found to be *per se* violative of the Sherman Act in *Maricopa.* Nevertheless, I rule that the legal and economic principles underlying the decision in *Maricopa* may be appropriately applied to the controversy now before this Court.

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[19] This Court considers itself bound by the decision in *Maricopa,* but notes that Justices O'Connor and Blackmun recused themselves and that Chief Justice Burger and Justices Powell and Rhenquist dissented. How the Supreme Court would rule on this same issue in the next case to come before it is anyone's guess.

In *Maricopa*, the Supreme Court examined a maximum fee arrangement that was substantially similar to the Blue Shield system which plaintiffs now challenge. The defendant in that case, the Maricopa County Medical Society, established the Maricopa Foundation for Medical Care, a non-profit corporation composed of approximately 70% of the doctors engaged in private practice in Maricopa County, Arizona. The foundation, by agreement of its member doctors, established a schedule of maximum fees that participating doctors agreed to accept as payment in full for services performed for patients insured under plans approved by the foundation. A patient who was insured by a foundation-endorsed plan was guaranteed complete coverage if he or she was treated by a foundation member; if the doctor's bill exceeded the foundation's maximum fee, the foundation disallowed the excess pursuant to the doctor's membership agreement.[20] The patient was free to go to a nonmember physician and was covered for charges that did not exceed the fee schedule. He was, however, liable for any amount in excess of the foundation payment. Participating doctors were free to charge higher fees to uninsured patients than they charged to insured patients and they were also permitted to charge any patient less than the schedule maximum. Seven insurance companies, representing a maximum of 63% of the prepaid health care market, underwrote health plans approved by the foundation. 457 U.S. at 341 n.11.

Certainly, the most significant difference between the plan struck down in *Maricopa* and the Blue Shield plan currently

[20] The physicians' agreement in *Maricopa* provided in part that the physician agreed "to be bound ... with respect to maximum fees ... by any fee determination by the [f]oundation consistent with the schedule adopted by the [foundation physician] membership...." The agreement also provided that foundation members "understand and agree that participating membership in the [f]oundation shall not affect the method of computation or amount of fees billed by [the physician] with respect to any medical care for any patient." 457 U.S. at 359 (Powell, J., dissenting).

under challenge in this case is that the maximum price levels in *Maricopa* were fixed by the doctors themselves, rather than by a medical service corporation like Blue Shield. The restraint in *Maricopa* was thus a classic example of a horizontal maximum price-fixing agreement between competitors. Accordingly, the Supreme Court struck down the agreement under the *per se* rule against price-fixing. *Id.* at 348.

The mere fact that the Blue Shield plan in this case does not constitute *per se* horizontal price-fixing does not make its adverse impact on competition any less objectionable than the plan struck down by the Supreme Court in *Maricopa*.[21] The determinative factor in any § 1 analysis is the impact, or the probable impact, of a restraint on competition, not the means employed to effect that impact.

When the Supreme Court reversed the Court of Appeals for the Ninth Circuit in *Maricopa* and ruled that the maximum fee arrangements, as price-fixing agreements, were *per se* unlawful under § 1 of the Sherman Act, the Court was

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[21] In *Maricopa*, the Court reflected on the procedural aspects of the creation of a fee schedule, and noted that an insurer, such as Blue Shield, is itself capable of creating a fee schedule through altogether different means:

> In order to create an insurance plan under which the doctor would agree to accept as full payment a fee prescribed in a fixed schedule, someone must canvass the doctors to determine what maximum prices would be high enough to attract sufficient numbers of individual doctors to sign up but low enough to make the insurance plan competitive. In this case that canvassing function is performed by the foundation; the foundation then deals with the insurer. It would seem that an insurer could simply bypass the foundation by performing the canvassing function and dealing with the doctors itself. Under the foundation plan, each doctor must look at the maximum-fee schedule fixed by his competitors and vote for or against approval of the plan (and, if the plan is approved by majority vote, he must continue or revoke his foundation membership). A similar, if to some extent more protracted, process would occur if it were each insurer that offered the maximum-fee schedule to each doctor. *Id.* at 353-4 n.28.

concerned primarily with the restraint's anticompetitive impact on the market for physicians' services and the resultant long-term negative effect on the quality and availability of health care. Justice Stevens, writing for the Court, observed:

> In this case the rule is violated by a price restraint that tends to provide the same economic rewards to all practitioners regardless of their skill, their experience, their training, or their willingness to employ innovative and difficult procedures in individual cases. Such a restraint also may discourage entry into the market and may deter experimentation and new developments by individual entrepreneurs. It may be a masquerade for an agreement to fix uniform prices, or it may in the future take on that character. 457 U.S. at 348.

Indeed, many of these anticompetitive effects have materialized in the present case. As the Blue Shield methodology has evolved away from the unrestricted usual and customary charge method incorporating the ban, the restrictive effect of the ban on balance billing has become more pronounced. I find that the evidence establishes that over the last six years, since the adoption of the Amended Schedule of Benefits, defendants have limited the annual percentage increases in the "customary" (or Level II) charges, with the result that the usual and customary charge methodology has taken on many of the functional attributes of a fee schedule system.[22] The percentage of claims paid at the "customary" level (Level II) fixed by Blue Shield, rather than at either the "usual charge" level (Level I), or the submitted charge level, has increased significantly. In fiscal year 1980, approximately 35% of all claims for services were paid at Level II rates; in 1981 that percentage increased to nearly 40%, and in fiscal year 1982, approximately 46% of all claims were paid at the "customary" level as adjusted by Blue Shield.

[22] Internal Blue Shield memoranda show that the purpose of the compression of the Level I and Level II fees is to produce a fee schedule for Blue Shield payments. *See, e.g.*, Plaintiffs' Exhibit 45.

Thus I find that, in effect, Blue Shield has converted its usual and customary charge methodology into a fee schedule system with all of the operational characteristics and competitive effects associated with such a system.

As the Supreme Court predicted in *Maricopa*, those doctors in Massachusetts wanting to compete by offering innovative or "premium" services — services requiring more of the doctors' time and expense — are discouraged from doing so because defendants' pricing structure presumes that doctors' services are fungible. Defendant Blue Shield pays all doctors at the same "customary" maximum price level regardless of their levels of skill, their experience, their levels of training, their willingness to employ new procedures, or the levels of care they provide. Thus, the Blue Shield maximum fee system permits no financial reward for excellence, nor does it provide an incentive for individual qualitative improvement or innovation.

Dr. Frech testified that the Blue Shield system makes a physician's total income dependent almost entirely on volume — the number of procedures performed — rather than on the time and effort expended in the care of a particular patient. Dr. Frech's observation is corroborated by the experience of Dr. Henry Brown, a Massachusetts physician who is one of the plaintiffs in this case. Dr. Brown's experience provides an example of how the Blue Shield system produces the harmful effects envisioned by the Supreme Court in *Maricopa*.

I find that Dr. Brown is a surgeon who has been associated with the Harvard Surgical Services at Boston City Hospital since 1963, and is the head of the Hand Teaching Service at Harvard. Dr. Brown became a Blue Shield participating physician in 1963, and remained one until 1978 when he resigned rather than bow to the above-mentioned pressures to increase his patient load and compromise the quality of care provided. Following his resignation, Dr. Brown found that he was unable to maintain a viable practice in Massachu-

setts: when prospective patients learned that Blue Shield would neither pay Dr. Brown directly, since he was no longer a participating physician, nor reimburse the patients directly for services rendered by him, "the great majority of them felt that they had paid their premiums, and [they] would go to another physician." Thus, following his resignation from Blue Shield, Dr. Brown determined that to survive economically he had to shift the emphasis of his practice to out-of-state patients.

I find that Dr. Brown now maintains a small private practice in Massachusetts, while serving as Chief of the Hand Clinic and Director of Rehabilitation Medicine at the Veterans Administration Hospital in Manchester, New Hampshire, and that, at the present time, only 20% of Dr. Brown's income is derived from services provided to Massachusetts residents on a fee-for-service basis. I find that not only has Dr. Brown's freedom to compete in the market for physicians' services in Massachusetts been adversely affected, but also that his services are less available to Massachusetts residents, subscribers and non-subscribers alike, as a direct result of the Blue Shield plan.

Similarly, as the Court in *Maricopa* predicted, the ban on balance billing has had the effect of discouraging innovation, and of discouraging the development and application of new medical procedures in Massachusetts. The testimony of Dr. Stephen Hedburg illustrates how the Blue Shield plan discourages both innovations in, and the widespread adoption of, new medical techniques. Dr. Hedburg is a Blue Shield participating physician, specializing in surgery and clinical endoscopy at Massachusetts General Hospital. In addition, he serves as a clinical professor of surgery at Harvard Medical School. Dr. Hedburg testified that in the early 1970's he was one of the first doctors in the country, and the first doctor in Massachusetts, to perform a new procedure known as "colon-

oscopy with polypectomy."[23] I find that this outpatient procedure had a significantly lower cost, required much less in-hospital time, and involved much less risk to the patient, than the traditional surgical alternative which requires hospitalization and a much greater out-of-pocket expense.[24]

In 1974, when Dr. Hedburg's average charge for the colonoscopy with polypectomy was $500, the average Blue Shield reimbursement for the procedure was $170. At the same time, Dr. Hedburg received for the identical procedure an average of $175 from Medicare, $245 from Medicare with complimentary, and $425 from other sources. The gap has since narrowed. Dr. Hedburg currently charges around $800 and Blue Shield pays close to $700. The out-of-pocket cost for the traditional surgical alternative is now approximately $6,000.

It is axiomatic that neither Dr. Hedburg nor any other doctor has an inalienable right to receive his asking price for this procedure, or for any other procedure, nor do the antitrust laws protect any particular level of doctor compensation. However, the antitrust laws are intended to preserve and foster incentives to compete and to innovate. Blue Shield's reluctance to provide full remuneration for innovative procedures, coupled with its ban on balance billing, discourages physicians from undertaking the training and purchasing the equipment necessary to learn and offer the safer, innovative, relatively inexpensive procedure.[25] As a result, doctors in

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[23] A colonoscopy is a form of endoscopy in which the interior of the colon is examined using a colonoscope, a flexible fiberoptic instrument approximately six feet in length, which is introduced into the colon. The endoscopist is able to examine the lining of the colon in great detail and is capable of using the same instrument to perform biopsies and other surgical procedures within the colon. The removal of a benign tumor is called a polypectomy.

[24] The true economic cost of the procedure also includes wages foregone by a patient during the longer hospitalization and recovery.

[25] Defendants claim that the low initial level of payment by Blue Shield was due to an insufficiency of fee data and to incorrect fil-

Massachusetts have been reluctant to learn the new colonoscopy with polypectomy procedure. It is likely that, for those persons contemplating surgery in the early 1970's, including both Blue Shield members and nonmembers, the new procedure, with its many advantages, was a less available and less attractive medical alternative than it might have been had competitive market forces not been restrained.

While the parties have stipulated that the ban on balance billing has had no impact on *average* physician practice income, I find that the Blue Shield payment scheme "tends to provide the same economic rewards to all practitioners regardless of their skills, their experience, [or] their training," *Maricopa*, 457 U.S. at 348, and I find that the result of such a plan is that, in Massachusetts, superior physicians are undercompensated and below-average physicians are overcompensated.

Moreover, Blue Shield deters above-average or experienced doctors from entering the market for physicians' services in Massachusetts through its policy regarding compensation of "new" doctors. No matter how many years an experienced doctor has been in practice in a state outside of Massachusetts, and no matter how high the doctor's level of skill and experience, the maximum amount Blue Shield will pay any doctor in his first year of practice in Massachusetts is limited to the 50th percentile of the "customary charges" for that

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ings by physicians. Further, they argue that the initial interim fee established by Blue Shield's fee committee, though perhaps too low, was nonetheless reasonable. Both of these arguments miss the point. The crucial point in plaintiffs' argument is not that Blue Shield's fee determination was ultimately unreasonable (though it may have been), but that the low initial fee, in conjunction with the ban, in fact deterred physician adoption of the new procedure. Precisely because a low fee determination by Blue Shield, even if made in good faith, can have these deleterious effects, it is especially important that during the early, formative development of a medical technique, the market, not Blue Shield, should determine the relative value of a procedure.

procedure. Massachusetts may in fact be insulated from the immediate effects of such a disincentive, for many superior doctors are no doubt willing to forego some financial rewards in order to practice in the Boston area with its high caliber medical personnel, and its world-renowned teaching hospitals and facilities. Nevertheless, I find that, while there has not been a decrease in the total number of doctors practicing in the Commonwealth, the Blue Shield plan as it presently exists tends to make Massachusetts a less attractive place to practice medicine than it would be absent the ban on balance billing.

Plaintiffs contend, but failed to prove, that the current Blue Shield payment plan has caused an exodus of practicing physicians from Massachusetts. Data received in evidence from the American Medical Association, from Blue Shield, and from the Massachusetts Medical Society, a plaintiff in this case, show, and I find, that there has not been a substantial migration of physicians out of Massachusetts. Rather, I find that the number of practicing physicians in Massachusetts has increased steadily during the past decade.

The policy considerations which the Supreme Court found to be persuasive in *Maricopa* are even more compelling on the markedly different factual record of this case. The Supreme Court in *Maricopa*, even while recognizing the voluntary and non-binding nature of the physicians' participating in the foundation, held that the plan had a disturbing tendency to stifle medical innovation and to deter the investment of extra time and money on the part of physicians, to the ultimate detriment of quality health care. Those same policy concerns can only be heightened in this case by the fact that physician participation in the Blue Shield plan is not, in fact, voluntary. I find that resignation is not a viable alternative for Massachusetts physicians who believe that the Blue Shield Participating Physicians' Agreement inhibits their offering innovative or more time-consuming health care.

Another important difference between the two cases is that in *Maricopa* the Supreme Court was concerned with the economic effects of a plan covering 70% of the practicing physicians in *one county* in Arizona. In this case, participation is statewide and the restraint is thus more pervasive. Over 99% of the practicing physicians in the Commonwealth are bound by the price restrictions promulgated by Blue Shield. If a prospective patient living in Maricopa County, Arizona has been dissatisfied with the level or quality of care provided by the 70% of the doctors in the county who were members of the foundation, he was able either to turn to one of the 30% of the doctors in Maricopa County who were not members of the foundation or to a doctor in another county. A similarly dissatisfied prospective patient in Massachusetts must look to a doctor in another state, an unlikely eventuality, or turn to one of the very few non-participating physicians in Massachusetts. Thus, the impact of the illegal restraint in *Maricopa* was much more limited than the impact which is generated by the Blue Shield plan now under attack, both in terms of the adverse impact on patients' choice of doctor and the effect on competition among doctors in general.

Defendants seek to counter plaintiffs' reliance on *Maricopa* with two arguments. First, they argue that the Blue Shield plan, incorporating the ban on balance billing, has no anti-competitive effect on competition in the physicians' services market because doctors remain free to charge any fee that they wish. On this record, however, that argument is misleading and factually incorrect. Certainly, doctors remain able to announce any fee level they choose. But for services rendered to a majority of the state's population the ban on balance billing prevents them from collecting more than the amount Blue Shield is willing to pay on behalf of its subscribers. The economic freedom protected by the Sherman Act is not the meaningless freedom simply to ask for any particular fee, but rather the fundamental freedom to bar-

gain for, and to receive, a market-determined price for services rendered.

Moreover, defendants' argument rests on the notion that Blue Shield does not set physicians' fees, but merely establishes the levels at which it will pay doctors for services rendered to its subscribers. That distinction was implicitly rejected by the Supreme Court in *Maricopa*. In that case, participating doctors agreed to a schedule of maximum fees which they would accept as payment in full for health services provided to certain policyholders, although they specifically retained the "right" to charge a patient any fee of their choosing.[26] Despite the explicit contractual disclaimer stating that the agreement did not restrict the pricing freedom of any of the foundation's member doctors, the Supreme Court characterized the maximum fee arrangement as one which regulated *prices* and price competition.

Second, defendants argue that because Blue Shield's payments subject to the ban on balance billing constitute only 13-35% of total physician revenue, Blue Shield's payments affect too small a proportion of total physician revenue to enable it to exert control over prices in the market for physicians' services. It is not, however, plaintiffs' burden to establish that Blue Shield has absolute control over pricing in the market for physicians' services. Instead, plaintiffs allege, and I rule that they have in fact proved, that Blue Shield's current system tends to distort, eliminate, and impede price competition among physicians. The Supreme Court has long held that inability to *control* prices does not save an otherwise illegal scheme.

> Any combination which tampers with price structures is engaged in an unlawful activity. Even though the members of the price-fixing group were in no position to control the market, to the extent that they raised, lowered, or stablilized prices they would be directly interfering with the free play of market forces.

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[26] See Footnote Number 20, *supra*, for the exact wording of the contract.

United States v. Socony-Vacuum Oil Co., Inc., 310 U.S. 150, 221 (1940). Since I find that defendants' usual and customary charge method, as applied together with the ban on balance billing, has the effect of fixing prices in the market for physicians' services and of otherwise interfering with the free play of market forces, I rule that it violates § 1 of the Sherman Act. The testimony at trial establishes, and I find, that Blue Shield plans which incorporate the ban on balance billing substantially reduce the level of price competition in the market for physicians' services in Massachusetts.

In summary, I rule that defendants' ban on balance billing imposes an unreasonable restraint on competition in the market for physicians' services in Massachusetts. I find that the restraint has a deleterious effect on competition in that market far exceeding the mere diminution in doctors' earnings that results directly from the terms of the Participating Physicians' Agreement. I find further that this effect is not offset by any demonstrable procompetitive effect. The ban interferes substantially with doctor's basic freedom and ability to compete — to offer a variety of medical services to the public in return for a price determined by market forces. As predicted by the Supreme court in *Maricopa*, the restraint has had, and continues to have, the effect of discouraging innovation and of discouraging the adoption of new medical techniques. In addition, I find that the ban reduces the quality of medical care in Massachusetts because it suppresses the normal market-generated incentives for physicians to improve and refine their services. For these reasons, I rule that the ban on balance billing unreasonably restrains trade in the market for physicians' services in Massachusetts in violation of Section 1 of the Sherman Act and that its further implementation should be enjoined.

C. Plaintiffs' Section 2 Claims

In light of this Court's disposition of plaintiffs' claim under § 1 of the Sherman Act, and further, because plaintiffs pray

for identical relief under § 2 of the Act, I do not believe a lengthy analysis of the merits of the remaining Section 2 claim is warranted. Succinctly stated, I find plaintiffs have not sustained their burden of proving that Blue Shield has monopolized the market for physicians' services in Massachusetts.

Order accordingly.

Andrew A. Caffrey, Ch. J.

Appendix C

United States Court of Appeals For The First Circuit

No. 84-1241

JAMES P. KARTELL, M.D., ET. AL.,
Plaintiffs, Appellees,

v.

BLUE SHIELD OF MASS., INC.,
Defendant, Appellant.

No. 84-1290

JAMES P. KARTELL, M.D., ET. AL.,
Plaintiffs, Appellees,

v.

BLUE SHIELD OF MASS., INC., ET AL.,
Defendants, Appellees.

MASSACHUSETTS MEDICAL SOCIETY, ET AL.,
Intervenors/Plaintiffs, Appellants.

No. 84-1303

JAMES P. KARTELL, M.D., ET. AL.,
Plaintiffs, Appellees,

v.

BLUE SHIELD OF MASS., INC., ET AL.,
Defendants, Appellees.

COMMISSIONER OF INSURANCE,
Intervenors/Defendant, Appellant.

JUDGMENT

Entered: November 28, 1984

These causes came on to be heard on appeals from the United States District Court for the District of Massachusetts, and were argued by counsel.

Upon Consideration whereof, It is now here ordered, adjudged and decreed as follows: The district court's finding that the ban on balance billing is unlawful is reversed, and the district court's injunction is vacated. In all other respects the order of the district court is affirmed. No Costs.

By the Court:

FRANCIS P. SCIGLIANO, Clerk.

By Janice M. O'Neil
Supervisory Deputy.

[cc: Messrs. Witherby, Fremont-Smith,
Springer and Mahoney.]

Appendix D

United States District Court
District of Massachusetts

Civil Action
No. 78-594-C

JAMES P. KARTELL, M.D., ET. AL.,
Plaintiffs

v.

BLUE SHIELD OF MASSACHUSETTS, INC., ET. AL.,
Defendants.

ORDER

March 19, 1984

CAFFREY, Ch. J.

In accordance with opinion filed this date, it is ORDERED:

1. Blue Shield is enjoined from implementing the so-called ban on balance billing effective as of the first day of the month following that in which this judgment becomes final.
2. Complaint dismissed as to Blue Cross.

Andrew A. Caffrey, Ch. J.

United States District Court
District of Massachusetts

Civil Action
No. 78-594-C

JAMES P. KARTELL, M.D., ET. AL.,
Plaintiffs,

v.

BLUE SHIELD OF MASSACHUSETTS, INC., ET. AL.,
Defendant.

AMENDED ORDER

March 22, 1984

CAFFREY, Ch. J.

The Order entered herein on March 19, 1984 is amended to add a third paragraph thereto so that the order will read:

In accordance with opinion filed March 19, 1984, it is ORDERED:

1. Blue Shield is enjoined from implementing the so-called ban on balance billing effective as of the first day of the month following that in which this judgment becomes final.
2. Complaint dismissed as to Blue Cross.
3. Complaint dismissed as to the Massachusetts Commissioner of Insurance, intervenor-defendant.

Andrew A. Caffrey, Ch. J.